

SENATE No. 2584

The Commonwealth of Massachusetts

**In the One Hundred and Ninety-Second General Court
(2021-2022)**

An Act addressing barriers to care for mental health.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

1 SECTION 1. Chapter 6A of the General Laws is hereby amended by striking out section
2 16P, as appearing in the 2020 Official Edition, and inserting in place thereof the following 2
3 sections:-

4 Section 16P. (a) For the purposes of this section, the following words shall have the
5 following meanings unless the context clearly requires otherwise:

6 “Awaiting residential disposition”, waiting not less than 72 hours to be moved from an
7 acute level of psychiatric care to a less intensive or less restrictive, clinically-appropriate level of
8 psychiatric care.

9 “Boarding”, waiting not less than 12 hours to be placed in an appropriate therapeutic
10 setting after: (i) being assessed; (ii) determined to be in need of acute psychiatric treatment, crisis
11 stabilization unit placement, community-based acute treatment, intensive community-based acute
12 treatment, continuing care unit placement or post-hospitalization residential placement; and (iii)

13 receiving a determination from a licensed health care provider to be medically stable without
14 needing urgent medical assessment or hospitalization for a physical condition.

15 “Children and adolescents”, individuals who are not more than 22 years of age.

16 (b) The secretary of health and human services shall facilitate the coordination of services
17 for children and adolescents awaiting clinically-appropriate behavioral health services by
18 developing and maintaining a confidential and secure online portal that enables health care
19 providers, health care facilities, payors and relevant state agencies to access real-time data on
20 children and adolescents who are boarding, awaiting residential disposition or in the care or
21 custody of a state agency and are awaiting discharge to an appropriate foster home or a
22 congregate or group care program. The online portal and information contained in the online
23 portal shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or under
24 chapter 66.

25 (c) The online portal shall include, but not be limited to, the following data: (i) the total
26 number of children and adolescents boarding, including a breakdown, by location, of where the
27 children and adolescents are boarding, which shall include, but not be limited to, hospital
28 emergency rooms, emergency services sites, medical floors after having received medical
29 stabilization treatment or their homes; (ii) the total number of children and adolescents awaiting
30 residential disposition, including a breakdown, by facility type, of where children and
31 adolescents are awaiting residential disposition and the level of care or type of placement sought;
32 and (iii) the total number of children and adolescents in the care or custody of a state agency who
33 are hospitalized and have waited not less than 72 hours for discharge to an appropriate foster

34 home or a congregate or group care program after having been determined to no longer need
35 hospital-level care.

36 (d) For each category of data included under subsection (c), the online portal shall
37 include: (i) the average wait time for discharge to the appropriate level of care or placement; (ii)
38 the level of care required as determined by a licensed health care provider; (iii) the primary
39 behavioral health diagnosis and any co-morbidities relevant for the purposes of placement; (iv)
40 the primary reason for boarding, awaiting residential disposition or, for children and adolescents
41 in the care or custody of a state agency, for having waited not less than 72 hours for discharge to
42 an appropriate foster home or a congregate or group care program after an assessment that
43 hospital-level care is no longer necessary; (v) whether the children and adolescents are in the
44 care or custody of the department of children and families or the department of youth services or
45 are eligible for services from the department of mental health or the department of
46 developmental services; (vi) data on the insurance coverage type for the children and
47 adolescents; and (vii) data on the ages, race, ethnicity, preferred spoken languages and gender of
48 the children and adolescents.

49 (e) The online portal shall include information on the specific availability of pediatric
50 acute psychiatric beds, crisis stabilization unit beds, community-based acute treatment beds,
51 intensive community-based acute treatment beds, continuing care beds and post-hospitalization
52 residential beds. The online portal shall also enable a real-time bed search within a specified
53 geographic region that shall include, but not be limited to: (i) the total number of beds licensed
54 by the department of mental health, the department of public health and the department of early
55 education and care; (ii) the total number of available beds, broken down by location, licensing
56 authority, age ranges and the distance, in miles, from where a child or adolescent currently

57 resides and is boarding; (iii) the average daily bed availability, broken down by licensing
58 authority and age ranges; (iv) daily bed admissions, broken down by licensing authority and age
59 ranges; (v) the facility or location in which a child or adolescent was admitted; (vi) daily bed
60 discharges, broken down by licensing authority and age ranges; and (vii) the average length of
61 stay in a bed, broken down by licensing authority and age ranges.

62 (f) Quarterly, not later than 14 days after the end of the preceding quarter, the secretary
63 shall report on the status of children and adolescents who are boarding, awaiting residential
64 disposition or in the care or custody of a state agency and awaiting discharge to an appropriate
65 foster home or a congregate or group care program. The report shall include a summary and
66 assessment of the data published on the online portal under subsections (c) to (e), inclusive, for
67 the immediately preceding quarter and may include a summary and assessment of the data over
68 several quarters; provided, however, that the report shall present the data in an aggregate and de-
69 identified form. The report shall be submitted to the children’s behavioral health advisory
70 council established in section 16Q, the office of the child advocate, the health policy
71 commission, the clerks of the senate and the house of representatives, the joint committee on
72 health care financing, the joint committee on mental health, substance use and recovery, the joint
73 committee on children, families and persons with disabilities and the senate and house
74 committees on ways and means.

75 Section 16P½. (a) For the purpose of this section, “adults” shall mean individuals who
76 are not less than 23 years of age.

77 (b) The secretary of health and human services shall facilitate psychiatric and substance
78 use disorder inpatient admissions for adults seeking to be admitted from an emergency

79 department or hospital medical floor by developing and maintaining a confidential and secure
80 online portal that enables health care providers, health care facilities and payors to conduct a
81 real-time bed search for patient placement. The online portal shall provide real-time information
82 on the specific availability of all licensed psychiatric and substance use disorder inpatient beds
83 that shall include, but not limited to: (i) location; (ii) care specialty; and (iii) insurance
84 requirements. The online portal and information contained in the online portal shall not be a
85 public record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66.

86 SECTION 2. Said chapter 6A is hereby further amended by inserting after section 16DD
87 the following section:-

88 Section 16EE. (a) There shall be an office of behavioral health promotion within the
89 executive office of health and human services. The office shall be under the supervision and
90 control of a director of behavioral health promotion who shall be appointed by and report to the
91 secretary of health and human services.

92 (b) The office shall facilitate the coordination of all executive office, state agency,
93 independent agency and state commission activities that promote behavioral health and wellness.
94 The office shall set goals for the promotion of behavioral health and substance use disorder
95 services and programming. The office shall fully integrate health equity principles and apply a
96 health equity framework to all its duties and obligations. The office shall prepare and implement
97 an annual plan for the promotion of behavioral health. The office shall collaborate with the
98 executive office of health and human services, the executive office of education, the executive
99 office of elder affairs, the department of mental health, the department of public health, the
100 department of children and families, department of youth services, the department of veterans'

101 services, the department of early education and care, the department of elementary and
102 secondary education, the office for refugees and immigrants, the office of health equity, the
103 office of the child advocate and any other relevant office, agency or commission. The office shall
104 facilitate communication and partnership between relevant entities to develop promote
105 understanding of the intersections between entity activities and behavioral health promotion.

106 (c) The office shall: (i) facilitate the development of interagency initiatives that: (A) are
107 informed by the science of promotion and prevention; (B) advance health equity and trauma-
108 informed care; and (C) address the social determinants of health; (ii) develop and implement a
109 comprehensive plan to strengthen community and state-level promotion programming and
110 infrastructure through training, technical assistance, resource development and dissemination and
111 other initiatives; (iii) advance the identification and dissemination of evidence-based practices
112 designed to further promote behavioral health and the provision of supportive behavioral health
113 services and programming to address substance use conditions and associated disability and to
114 prevent violence through trauma-specific intervention and rehabilitation; (iv) collect and analyze
115 data measuring population-based indicators of behavioral health from existing data sources,
116 track changes over time and make programming and policy recommendations to address the
117 needs of populations at greatest risk; (v) coordinate behavioral health promotion and wellness
118 programs, campaigns and initiatives; (vi) provide staffing support for the commission on
119 community behavioral health promotion established in section 219 of chapter 6; and (vii)
120 ascertain the mental health needs of veterans. The office may enter into service agreements with
121 the department of mental health or the department of public health to fulfill the obligations of the
122 office.

123 (d) Annually, not later than July 1, the office shall report on its progress, and the overall
124 progress of the commonwealth, toward promoting behavioral health and wellness and preventing
125 substance use conditions and violence. When possible, the report shall use quantifiable measures
126 and comparative benchmarks. The report shall be filed with the governor, the clerks of the senate
127 and house of representatives and the joint committee on mental health, substance use and
128 recovery. The report shall be posted on the official website of the commonwealth.

129 Section 16FF. (a) As used in this section, the following words shall have the following
130 meanings unless the context requires otherwise:

131 “Community behavioral health centers”, organizations that are designated by the
132 executive office of health and human services, licensed clinics that hold a contract with the
133 department of mental health to provide community-based mental health services and other
134 licensed clinics designated by the department of public health.

135 “Community crisis stabilization program”, a program providing crisis stabilization
136 services with the capacity for diagnosis, initial management, observation, crisis stabilization and
137 follow-up referral services to all persons in a home-like environment, including, but not limited
138 to, emergency service providers and restoration centers.

139 (b) The secretary of health and human services shall designate at least one 988 crisis
140 hotline center that shall operate 24 hours a day, 7 days a week to provide crisis intervention
141 services and crisis care coordination to individuals accessing the federally-designated 988
142 suicide prevention and behavioral health crisis hotline.

143 (c) A 988 crisis hotline center shall: (i) meet the United States Department of Health and
144 Human Services’ Ambulatory Behavioral Health System standards and the National Suicide

145 Prevention Lifeline requirements and best practices guidelines for operational and clinical
146 standards; (ii) provide data, report and participate in evaluations and related quality improvement
147 activities as required by the United States Department of Health and Human Services’; (iii)
148 utilize technology, including, but not limited to, chat and text capabilities, that is interoperable
149 between and across crisis and emergency response systems and services, including 911 and 211,
150 as necessary; (iv) have the authority to deploy crisis and outgoing services, including mobile
151 behavioral health crisis responders, and coordinate access to crisis triage, evaluation and
152 counseling services, community crisis stabilization programs or other resources as appropriate;
153 (v) maintain standing partnership agreements with community behavioral health centers and
154 other behavioral health programs and facilities, including programs led by individuals who are or
155 were consumers of mental health or substance use disorder supports or services; (vi) coordinate
156 access to crisis evaluation, counseling, receiving and stabilization services for individuals
157 accessing the 988 suicide prevention and behavioral health crisis hotline through appropriate
158 information sharing regarding availability of services; (vii) have the capability to serve high-risk
159 and specialized populations including, but not limited to, people with co-occurring substance use
160 and mental health conditions and people with autism spectrum disorders or intellectual or
161 developmental disabilities; (viii) have the capability to serve people of diverse races, ethnicities,
162 ages, sexual orientations and gender identities with linguistically and culturally competent care;
163 (ix) have the capability to provide crisis and outgoing services within a reasonable time period in
164 all geographic areas of the commonwealth; and (x) provide follow-up services to individuals
165 accessing the 988 suicide prevention and behavioral health crisis hotline.

166 (d) (1) There shall be a state 988 commission within the executive office of health and
167 human services to provide ongoing strategic oversight and guidance in all matters regarding 988
168 service in the commonwealth.

169 (2) The commission shall review national guidelines and best practices and make
170 recommendations for implementation of a statewide 988 suicide prevention and behavioral
171 health crisis system, including any legislative or regulatory changes that may be necessary for
172 988 implementation and recommendations for funding that may include the establishment of user
173 fees. The commission shall also advise on promoting the 988 number including, but not limited
174 to, recommendations for including information about calling 988 on student identification cards
175 and on signage in locations where there have been known suicide attempts.

176 (3) The commission shall consist of: the secretary of health and human services or the
177 secretary's designee, who shall serve as chair; the secretary of public safety and security or the
178 secretary's designee; the commissioner of mental health or the commissioner's designee; the
179 commissioner of public health or the commissioner's designee; the executive director of the
180 Massachusetts Behavioral Health Partnership or the executive director's designee; the executive
181 director of the state 911 department or the executive director's designee; the executive director of
182 Mass 2-1-1 or the executive director's designee; a representative designated by the
183 Massachusetts Chapter of the National Association of Social Workers, Inc.; a 911 dispatcher
184 designated by the Massachusetts Chiefs of Police Association Incorporated; an emergency
185 medical technician or first responder nominated by the Massachusetts Ambulance Association,
186 Incorporated; and the following members to be appointed by the chair: 1 representative from an
187 emergency service provider, nominated by the Association for Behavioral Healthcare, Inc.; 1
188 representative from the Association for Behavioral Healthcare, Inc.; 1 representative from a

189 suicide prevention hotline in the commonwealth, nominated by the Samaritans, Inc.; 1
190 representative from the Riverside Community Care, Inc. MassSupport program; 1 representative
191 from the Massachusetts Coalition for Suicide Prevention; 1 representative from the Children’s
192 Mental Health Campaign; 1 representative from the INTERFACE Referral Service at William
193 James College, Inc.; 1 representative from the National Alliance on Mental Illness of
194 Massachusetts, Inc.; 1 representative from the Parent/Professional Advocacy League, Inc.; 1
195 representative from the Massachusetts Association for Mental Health, Inc.; 1 representative from
196 the Boston branch of the National Association for the Advancement of Colored People; 1
197 representative from the American Civil Liberties Union of Massachusetts, Inc.; 1 representative
198 from the mental health legal advisors committee; and 3 persons who are or have been consumers
199 of mental health or substance use disorder supports or services. Every reasonable effort shall be
200 made to ensure representation from all geographic areas of the commonwealth.

201 (4) Annually, not later than March 1, the commission shall submit its findings and
202 recommendations to the clerks of the senate and house of representatives, the joint committee on
203 mental health, substance use and recovery and the joint committee on health care financing.

204 SECTION 3. Section 8 of chapter 6D of the General Laws, as appearing in the 2020
205 Official Edition, is hereby amended by inserting after the word “system”, in line 9, the following
206 words:- and trends in annual behavioral health expenditures.

207 SECTION 4. Said section 8 of said chapter 6D, as so appearing, is hereby further
208 amended by striking out, in line 94, the word “and” and inserting in place thereof the following
209 words:- , including behavioral health expenditures, and.

210 SECTION 5 Section 16 of said chapter 6D, as so appearing, is hereby amended by
211 inserting after the figure “176O”, in line 66, the following words:- , including a process for
212 identifying and referring matters to the division of insurance and the office of the attorney
213 general for review of compliance with state and federal mental health and substance use disorder
214 parity laws.

215 SECTION 6. Said chapter 6D is hereby further amended by adding the following 2
216 sections:-

217 Section 20. Every 3 years, the commission, in collaboration with the department of public
218 health, the department of mental health and the department of developmental services, shall
219 prepare a pediatric behavioral health planning report analyzing the status of pediatric behavioral
220 health in the commonwealth. The report shall include, but not be limited to: (i) a review of data
221 from the online portal established in section 16P of chapter 6A and the reports submitted to the
222 commission pursuant to subsection (f) of said section 16P of said chapter 6A; (ii) an analysis of
223 the availability of pediatric acute psychiatric beds, crisis stabilization unit beds, community-
224 based acute treatment beds, intensive community-based acute treatment beds, continuing care
225 unit beds and post-hospitalization residential beds, broken down by geographic region and by
226 sub-specialty, and an identification of any service limitations; (iii) an analysis of the capacity of
227 the pediatric behavioral health workforce to respond to the acute behavioral health needs of
228 children and adolescents across the commonwealth; (iv) any statutory, regulatory or operational
229 factors that may impact pediatric boarding under said section 16P of said chapter 6A; and (v) any
230 other information deemed relevant by the commission. The report shall be published on the
231 commission’s website.

232 Section 21. The commission shall develop a standard release form for exchanging
233 confidential mental health and substance use disorder information. The standard release form
234 shall be available in electronic and paper format and shall be accepted and used by all public and
235 private agencies, departments, corporations, provider organizations and licensed professionals
236 involved with the medical or behavioral health treatment of an individual experiencing mental
237 illness, serious emotional disturbance or substance use disorder. The commission shall
238 promulgate regulations for the proper use of the standard release form that shall comply with
239 federal and state laws relating to the protection of individually identifiable health information.

240 SECTION 7. Section 16 of chapter 12C of the General Laws, as appearing in the 2020
241 Official Edition, is hereby amended by striking out, in lines 41 to 43, inclusive, the words “and
242 (11) the impact of health care payment and delivery reform on the quality of care delivered in the
243 commonwealth” and inserting in place thereof the following words:- (11) the impact of health
244 care payment and delivery reform on the quality of care delivered in the commonwealth; and
245 (12) costs, cost trends, price, quality, utilization and patient outcomes related to behavioral health
246 service subcategories described in section 21A.

247 SECTION 8. Section 21A of said chapter 12C, as so appearing, is hereby amended by
248 adding the following sentence:- The investigation and study shall also include developing and
249 defining criteria for health care services to be categorized as behavioral health services, with
250 subcategories including, but not limited to: (i) mental health; (ii) substance use disorder; (iii)
251 outpatient; (iv) inpatient; (v) services for children; (vi) services for adults; and (vii) provider
252 type.

253 SECTION 9. Chapter 13 of the General Laws is hereby amended by striking out section
254 80, as so appearing, and inserting in place thereof the following section:-

255 Section 80. There shall be a board of registration of social workers that shall consist of:
256 the commissioner of children and families or a designee who shall be licensed as a certified
257 social worker or as an independent clinical social worker under sections 130 to 137, inclusive, of
258 chapter 112; the commissioner of mental health or a designee who shall be licensed as a certified
259 social worker or as an independent clinical social worker under said sections 130 to 137,
260 inclusive, of said chapter 112; and 7 persons to be appointed by the governor, 1 of whom shall be
261 a representative of an accredited school of social work, 3 of whom shall be licensed as certified
262 social workers or as independent clinical social workers under said sections 130 to 137,
263 inclusive, of said chapter 112, 1 of whom shall be an active member of an organized labor
264 organization representing social workers who shall be licensed under said sections 130 to 137,
265 inclusive, of said chapter 112 and 2 of whom shall be members of the general public . At least 1
266 member who is a licensed social worker and at least 1 member from the general public shall
267 represent an underserved population as defined by the United States Department of Health and
268 Human Services.

269 SECTION 10. Section 18 of chapter 15A of the General Laws, as so appearing, is hereby
270 amended by adding the following paragraph:-

271 Any qualifying student health insurance plan authorized under this chapter shall comply
272 with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity
273 Act of 2008, as amended, and any federal guidance or regulations relevant to the act, including
274 45 CFR Part 146.136, 45 CFR Part 147.136, 45 CFR Part 147.160 and 45 CFR Part

275 156.115(a)(3), and the benefit mandates and other obligations under section 47B of chapter 175,
276 section 8A of chapter 176A, section 4A of chapter 176B and sections 4, 4B and 4M of chapter
277 176G, as if the student health insurance plan was issued by such carriers licensed under said
278 chapters 175, 176A, 176B and 176G without regard to any limitation under section 1 of chapter
279 176J.

280 SECTION 11. Chapter 18C of the General Laws is hereby amended by inserting after
281 section 10 the following section:-

282 Section 10A. Annually, not later than April 1, the child advocate shall file a report
283 making recommendations for decreasing and eliminating the number of children and adolescents
284 awaiting clinically-appropriate behavioral health services. The report shall include a review of
285 the data included on the online portal established pursuant to section 16P of chapter 6A and the
286 report submitted to the child advocate in accordance with subsection (f) of said section 16P of
287 said chapter 6A. The child advocate's report shall be submitted to the governor, the children's
288 behavioral health advisory committee established in section 16Q of said chapter 6A, the clerks of
289 the senate and the house of representatives, the joint committee on health care financing, the
290 joint committee on mental health, substance use and recovery, the joint committee on children,
291 families and persons with disabilities and the senate and house committees on ways and means.

292 SECTION 12. Said chapter 18C is hereby further amended by striking out section 14, as
293 appearing in the 2020 Official Edition, and inserting in place thereof the following section:-

294 Section 14. (a) For the purposes of this section, the following words shall have the
295 following meaning unless the context clearly requires otherwise:

296 “Adverse childhood experiences”, events including, but not limited to: (i) experiencing
297 violence or abuse; (ii) witnessing violence in the home or community; (iii) having a close family
298 member die or attempt to die by suicide or die by overdose; (iv) living with a close family
299 member or caregiver with a substance use condition or with behavioral health needs; (v)
300 experiencing separation from a parent due to divorce, incarceration or child welfare intervention;
301 and (vi) experiencing chronic stress caused by community-level adversity, including the effects
302 of racism and discrimination.

303 “Protective factors”, experiences, circumstances or relationships that can mitigate an
304 adverse impact of trauma or promote resiliency.

305 “Trauma”, the result of an event, series of events or set of circumstances that is
306 experienced by an individual as physically or emotionally harmful or threatening and that has
307 lasting adverse effects on the individual’s functioning and physical, social, emotional or spiritual
308 well-being.

309 (b) The office shall convene a childhood trauma task force comprised of members of the
310 juvenile justice policy and data board established in section 89 of chapter 119 to study, report
311 and make recommendations on: (i) gender-responsive and trauma-informed approaches to
312 treatment for juveniles and youthful offenders in the juvenile justice system; and (ii) how the
313 commonwealth can better identify, support and provide services to children and youth who have
314 experienced trauma, with the goal of preventing future juvenile justice system involvement and
315 other negative life outcomes. The task force shall prioritize a juvenile or youthful offender’s
316 pathway into the juvenile justice system with the goal of reducing the likelihood of recidivism by

317 addressing the unique issues associated with juvenile or youthful offenders, including emotional
318 abuse, household mental illness, parental absence and household member incarceration.

319 (c) The task force shall: (i) review the benefits and risks of utilizing available tools,
320 protocols and best practices for targeted or universal screening for childhood trauma and
321 protective factors for all children and for children entering the foster care system; and (ii) make
322 recommendations regarding the manner and circumstances under which trauma or protective
323 factors screening should be used for all children and for children entering the foster care system.
324 The task force shall consider evidence regarding the efficacy of existing screening tools,
325 practices and protocols in various settings, including elementary and secondary educational
326 settings, pediatric settings, child welfare settings and juvenile justice settings, and the purpose
327 and goal of the tools, practices and protocols in supporting healthy child development. The task
328 force shall study models used in other states and make recommendations regarding whether it is
329 appropriate and feasible to adopt, amend or update existing tools, practices and protocols for use
330 in screening or assessing children in various settings, including children entering the foster care
331 system.

332 In circumstances where trauma screening and assessment is recommended by the task
333 force, the recommendations shall specify: (i) the population of children to be screened; (ii) the
334 types of professionals who are appropriate to administer a trauma screening; (iii) the training
335 required to support authorized professionals in the sound and efficient administration of
336 screenings; (iv) processes to ensure regular periodic review of protocols for screening; (v) ways
337 to ensure adequate reimbursement for providers responsible for screenings; and (vi) mechanisms
338 for providing post-screening assessment and intervention as appropriate.

339 In conducting the review and formulating recommendations under this section, the task
340 force shall seek input from relevant stakeholders and specialists including, but not limited to,
341 MassHealth, the division of insurance, the office of health equity, the Center on Child Wellbeing
342 and Trauma at the University of Massachusetts Medical School, the Foster Children Evaluation
343 Services at the University of Massachusetts Memorial Children’s Medical Center, the
344 Association for Behavioral Healthcare, Inc., the New England Council of Child and Adolescent
345 Psychiatry, the Children’s Mental Health Campaign, Boston Children’s Hospital Neighborhood
346 Partnerships Program, the Massachusetts Chapter of the American Academy of Pediatrics, the
347 Massachusetts Association for Infant Mental Health, the Child Trauma Training Center, the
348 Massachusetts Alliance for Families and the Child Witness to Violence Project at Boston
349 Medical Center.

350 (d) The task force shall consult with youth with lived adverse childhood experiences,
351 their guardians and support networks and other experts and conduct public stakeholder meetings
352 as necessary to ensure that perspectives from a diverse set of individuals and organizations
353 inform the task force’s work.

354 (e) Annually, not later than December 15, the childhood trauma task force shall report its
355 findings and recommendations to the governor, the clerks of the senate and the house of
356 representatives, the joint committee on the judiciary, the joint committee on public safety and
357 homeland security, the joint committee on mental health, substance use and recovery, the joint
358 committee on children, families and persons with disabilities, the joint committee on health care
359 financing and the chief justice of the trial court of the commonwealth.

360 SECTION 13. Said chapter 18C is hereby further amended by adding the following
361 section:-

362 Section 15. (a) The office shall convene a complex case resolution panel to resolve
363 matters referred to it under subsection (b). The panel shall include: the child advocate or a
364 designee, who shall serve as chair; the secretary of health and human services or a designee; the
365 assistant secretary of MassHealth or a designee; the commissioner of mental health or a
366 designee; the commissioner of children and families or a designee; the commissioner of
367 elementary and secondary education or a designee; the commissioner of early education and care
368 or a designee; the commissioner of developmental services or a designee; the commissioner of
369 youth services or a designee; and 2 persons to be appointed by the child advocate to serve for 2-
370 year terms, 1 of whom shall be a representative from an organization providing services to
371 children who are consumers of behavioral health services and programs and their families and 1
372 of whom shall be a representative from an organization that assists families in navigating the
373 behavioral health services system; provided, however, that the 2 individuals appointed for 2-year
374 terms shall recuse themselves from any matter in which they have a direct conflict of interest;
375 and provided further, that for the 2 individuals appointed for 2-year terms, if a vacancy occurs
376 prior to the end of one such individual's 2-year term, the vacancy shall be immediately filled by
377 the child advocate for the remainder of the term. The child advocate may require the
378 participation of a local educational agency or insurance carrier as a panel member when the
379 matter involves or may involve services provided by or paid for by such local educational agency
380 or insurance carrier. Panel members shall be empowered by the agency or local educational
381 agency to act on behalf of the agency or local educational agency in making decisions and
382 agreements.

383 (b) The panel shall review and resolve matters referred to the panel by a parent or legal
384 guardian, a legal advocate for a child, a state agency or state agency ombudsperson or a
385 physician or behavioral health provider authorized to act on behalf of a parent or legal guardian
386 who is seeking to access services for a child: (i) with complex behavioral health needs; (ii) who
387 has waited in a hospital emergency department or medical bed or at home for not less than 5 days
388 to be placed in an appropriate therapeutic setting or be provided with appropriate evaluations and
389 services after being assessed and determined to need psychiatric inpatient care, crisis
390 stabilization unit placement, community-based acute treatment, intensive community-based acute
391 treatment, a program of assertive community treatment, continuing care unit placement or
392 residential placement, including specialized foster care or partial hospitalization; and (iii) who
393 has been determined by a licensed health care provider to be medically stable and without need
394 for urgent medical assessment or hospitalization for a physical health condition. The panel shall
395 resolve such matters by addressing any administrative, financial or clinical barriers to such
396 services that arise from disputes between state agencies, MassHealth or local educational
397 agencies.

398 (c)(1) The panel shall convene not later than 1 business day after accepting a referral
399 under subsection (b). The panel shall address barriers to the child receiving appropriate services
400 including, but not limited to, the designation of a single state agency or local educational agency
401 to provide primary case management and the designation of the state agency or local educational
402 agency responsible for payment for services for which a child is eligible, including placement
403 and evaluations. The panel shall determine responsibility for aspects of complex cases in order to
404 best serve the needs of the child in an expeditious manner and to make interim designations of
405 case management or financial responsibility if no immediate agreement can be reached.

406 (2) If the lack of a primary case manager is impeding the child's access to services and if,
407 after 1 business day after the panel convenes for the first time on a matter, the panel cannot reach
408 consensus regarding the primary state or local educational agency responsible for case
409 management, the child advocate shall immediately designate a state agency or local educational
410 agency to act as the interim primary case manager until a final decision is issued on the matter
411 under subsection (d). Any assignment of interim primary case management responsibility by the
412 child advocate shall have no prejudicial value at the bureau of special education appeals, the
413 division of administrative law appeals or any other legal venue. If a civil, criminal or
414 administrative legal body makes a determination on primary case management responsibility that
415 is contrary to the interim responsibility assigned by the child advocate, the child advocate shall
416 align responsibility allocation in accordance with the decision of the legal body. No panel
417 member may receive reimbursement from any other panel member for any costs incurred as a
418 result of assignment of interim primary case management responsibility by the child advocate
419 under this section.

420 (3) If the child is unable to access services for which the child is eligible or entitled
421 because of a disagreement relative to the responsibility for payment among state agencies and
422 local educational agencies and if, after 1 business day after the panel convenes for the first time
423 on a matter, the panel cannot reach consensus relative to such responsibility for payment among
424 the state agencies or local educational agencies, the child advocate shall immediately require the
425 relevant state agencies and local educational agencies to enter into a temporary cost-sharing
426 agreement until a final decision is issued on the matter under subsection (d). Any assignment of
427 responsibility under a temporary cost-sharing agreement by the child advocate shall have no
428 prejudicial value at the bureau of special education appeals or the division of administrative law

429 appeals. If a civil, criminal or administrative body makes a determination that is contrary to the
430 temporary cost-sharing agreement, the child advocate shall align responsibility allocation in
431 accordance with the decision of the respective body. No panel member shall be entitled to
432 reimbursement from any other panel member for any costs incurred as a result of a temporary
433 cost-sharing agreement imposed by the child advocate under this section.

434 (d) Not later than 14 business days after the panel convenes for the first time on a matter,
435 the panel shall complete its review and, after consulting with the parents or legal guardian of the
436 child, relevant agencies and service providers and reviewing relevant materials, the panel shall
437 issue an order requiring services and placement to be provided for the child, who shall provide
438 such services and placement and who shall pay for such services and placement. To implement
439 the recommendations of the panel, the parent of a child with a disability and the local educational
440 agency may, in accordance with 20 U.S.C. 1414(d)(3)(D), agree not to convene an individualized
441 education plan meeting and instead develop a written document to amend or modify the child's
442 current individualized education plan.

443 If the lack of a primary case manager is impeding the child's access to services and the
444 panel cannot reach consensus regarding the agency or entity with primary responsibility for
445 managing the child's case, the child advocate shall immediately designate a state agency or local
446 educational agency to act as the primary case manager. The designated agency shall remain the
447 primary case manager until an alternative agreement is entered into or until the child no longer
448 qualifies for services.

449 If the child is unable to access services for which such child is eligible or entitled because
450 of a disagreement relative to the responsibility for payment among state agencies and local

451 educational agencies and the panel cannot reach consensus relative to such responsibility for
452 payment among the state agencies or local educational agencies, the child advocate shall
453 immediately require the relevant state and local agencies to enter into a cost-sharing agreement.
454 The cost-sharing agreement shall remain in effect until the child advocate is informed in writing
455 that an alternative cost-sharing agreement or a payment agreement has been entered into or until
456 the child no longer qualifies for services.

457 Any assignment of responsibility by the child advocate under this subsection shall have
458 no prejudicial value at the bureau of special education appeals or the division of administrative
459 law appeals. If a civil, criminal or administrative legal body makes a determination that is
460 contrary to the assignment of responsibility by the child advocate under this section, the child
461 advocate shall align responsibility allocation in accordance with the decision of the legal body.
462 No panel member shall be entitled to reimbursement from any other panel member for any costs
463 incurred as a result of an assignment of responsibility imposed by the child advocate under this
464 section.

465 Panel decisions under this subsection shall be issued to the parent or legal guardian, and
466 the individual who referred the case to the panel if such person is not the parent or legal
467 guardian, in writing not later than 3 business days after the decision and shall include the basis
468 for the decision, the basis for the denial of services, if any, and information regarding rights to
469 further review or appeal of a decision.

470 (e) If the parent or legal guardian of the child disputes the decision of the panel under
471 subsection (d), the parent or legal guardian may file an appeal with the division of administrative

472 law appeals, which shall conduct an adjudicatory proceeding and order any necessary relief
473 consistent with state or federal law, as applicable.

474 (f) If a local educational authority disputes the decision of the panel under subsection (d),
475 the local educational authority may file an appeal with the division of administrative law appeals,
476 which shall conduct an adjudicatory proceeding and order any necessary relief consistent with
477 state or federal law if the local educational authority has demonstrated that the decision of the
478 panel violates state or federal law, as applicable.

479 (g) The child advocate or the child advocate's designee shall have unrestricted access to
480 all electronic information systems' records, reports, materials and employees of a local
481 educational agency that is not otherwise restricted by state or federal law; provided, however,
482 that the child advocate shall be bound by any limitations on the use or release of information
483 imposed by law upon the party furnishing such information, except as provided in section 12.

484 (h) Nothing in this section shall be construed to entitle a child to services for which the
485 child would otherwise be ineligible under applicable agency laws or regulations.

486 (i) Notwithstanding chapters 66A, 112 and 119 or any other law related to the
487 confidentiality of personal data, the panel, the child advocate and the division of administrative
488 law appeals shall have access to and may discuss materials related to a case while the case is
489 under review once the parent or legal guardian has consented in writing and those having access
490 consent in writing to keep the materials confidential. Once the review is complete, all materials
491 shall be returned to the originating source.

492 (j) Nothing in this section shall limit: (i) the rights of parents, legal guardians or children
493 under chapter 71B, the Individuals with Disabilities Education Act, 20 U.S.C. 1400 et seq., or

494 section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794 et seq; or (ii) the rights of parents
495 under state or federal law to make decisions about a child’s health care.

496 (k) The child advocate shall publish an annual report on its website summarizing the
497 cases reviewed by the panel in the previous year, the length of time spent at each stage and their
498 final resolution; provided, however, that the report shall not include any information that could
499 foreseeably reveal the identity of the child.

500 (l) The child advocate shall promulgate regulations to implement this section.

501 SECTION 14. Chapter 26 of the General Laws is hereby amended by striking out section
502 8K, as appearing in the 2020 Official Edition, and inserting in place thereof the following
503 section:-

504 Section 8K. (a) The commissioner of insurance shall implement and enforce applicable
505 provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction
506 Equity Act of 2008, as amended, any federal guidance or regulations relevant to the act,
507 including 45 CFR Part 146.136, 45 CFR Part 147.136, 45 CFR Part 147.160 and 45 CFR Part
508 156.115(a)(3), and applicable state mental health parity laws, including, but not limited to,
509 section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and sections
510 4, 4B and 4M of chapter 176G, in regard to any carrier licensed under said chapters 175, 176A,
511 176B or 176G or any carrier offering a student health plan issued under section 18 of chapter
512 15A by:

513 (i) evaluating and resolving all consumer complaints alleging a carrier’s non-compliance
514 with state or federal laws related to mental health and substance use disorder parity as described
515 in subsection (f);

516 (ii) performing behavioral health parity compliance market conduct examinations of each
517 carrier not less than once every 36 months, or more frequently if noncompliance is suspected,
518 with a focus on: (A) nonquantitative treatment limitations under the federal Paul Wellstone and
519 Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and
520 applicable state mental health and substance use disorder parity laws, including, but not limited
521 to, prior authorization, concurrent review, retrospective review, step-therapy, network admission
522 standards, reimbursement rates, network adequacy and geographic restrictions; (B) denials of
523 authorization, payment and coverage; and (C) any other criteria determined by the division of
524 insurance, including factors identified through consumer or provider complaints; provided,
525 however, that: (1) a market conduct examination of a carrier subject to said chapter 175, 176A,
526 176B or 176G shall follow the procedural requirements in subsections 10, 11 and 15 of section 4
527 of said chapter 175 regarding notice and rebuttal of examination findings, subsequent hearings
528 and conflicts of interest; (2) the commissioner shall publicize the fees for a market conduct
529 examination under section 3B of chapter 7 and said subsection 11 of said section 4 of said
530 chapter 175; and (3) nothing contained in clause (ii) or in said section 4 of said chapter 175,
531 section 7 of said chapter 176A, section 9 of said chapter 176B and section 10 of said chapter
532 176G shall limit the commissioner's authority to use and, if appropriate, publish any final or
533 preliminary examination report, any examiner or company work papers or other documents or
534 any other information discovered or developed during the course of any examination in the
535 furtherance of any legal or regulatory action that the commissioner may, in their sole discretion,
536 deem appropriate;

537 (iii) requiring that carriers that provide mental health or substance use disorder benefits
538 directly or through a behavioral health manager as defined in section 1 of chapter 176O or any

539 other entity that manages or administers such benefits for the carrier comply with the annual
540 reporting requirements under section 8M;

541 (iv) updating applicable regulations as necessary to effectuate any provisions of the
542 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
543 2008, as amended that relate to insurance; and

544 (v) assessing a fee upon any carrier for the costs and expenses incurred in any market
545 conduct examination authorized by law, consistent with the costs associated with the use of
546 division personnel and examiners, the costs of retaining qualified contract examiners necessary
547 to perform an examination, electronic data processing costs, supervision and preparation of an
548 examination report and lodging and travel expenses; provided, however, that the commissioner
549 shall maintain active management and oversight of examination costs and fees to ensure that the
550 examination costs and fees comply with the National Association of Insurance Commissioners
551 market conduct examiners handbook unless the commissioner demonstrates that the fees
552 prescribed in the handbook are inadequate under the circumstances of the examination; and
553 provided further, that the commissioner or the commissioner's examiners shall not receive or
554 accept any additional emolument on account of any examination.

555 (b) The commissioner may impose a penalty against a carrier that provides mental health
556 or substance use disorder benefits, directly or through a behavioral health manager as defined in
557 section 1 of chapter 176O or any other entity that manages or administers such benefits for the
558 carrier, for any violation by the carrier or the entity that manages or administers mental health
559 and substance use disorder benefits for the carrier of state laws related to mental health and
560 substance use disorder parity or the mental health parity provisions of the federal Paul Wellstone

561 and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j),
562 as amended, and federal guidance or regulations issued under the act.

563 The amount of any penalty imposed shall be \$100 for each day in the noncompliance
564 period per product line with respect to each participant or beneficiary to whom such violation
565 relates; provided, however, that the maximum annual penalty under this subsection shall be
566 \$1,000,000; provided further, that for purposes of this subsection, the term “noncompliance
567 period” shall mean the period beginning on the date a violation first occurs and ending on the
568 date the violation is corrected.

569 A penalty shall not be imposed for a violation if the commissioner determines that the
570 violation was due to reasonable cause and not to willful neglect or if the violation is corrected
571 not more than 30 days after the start of the noncompliance period.

572 (c) If a violation of state laws related to mental health and substance use disorder parity
573 or the mental health parity provisions of the federal Paul Wellstone and Pete Domenici Mental
574 Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), as amended, and federal
575 guidance or regulations issued under the act, was likely to have caused denial of access to
576 behavioral health services, the commissioner shall require carriers to provide remedies for any
577 failure to meet the requirements of state laws related to mental health and substance use disorder
578 parity or the mental health parity provisions of the federal Paul Wellstone and Pete Domenici
579 Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), as amended, and
580 federal guidance or regulations issued under the act, which may include, but shall not be limited
581 to:

582 (i) requiring the carrier to change the benefit standard or practice, including updating plan
583 language, with notice to plan members;

584 (ii) providing training to staff on any changes to benefits and practices;

585 (iii) informing plan members of changes;

586 (iv) requiring the carrier to reprocess and pay all inappropriately denied claims to
587 affected plan members, notify members of their right to file claims for services previously denied
588 and for which members paid out-of-pocket and reimburse for services eligible for coverage
589 under corrected standards; or

590 (v) requiring the carrier to submit to ongoing monitoring to verify compliance.

591 (d) Any proprietary information submitted to the commissioner by a carrier as a result of
592 the requirements of this section shall not be a public record under clause Twenty-sixth of section
593 7 of chapter 4 or chapter 66; provided, however, that the commissioner may produce reports
594 summarizing any findings.

595 (e) The commissioner shall consult with the office of patient protection in connection
596 with any behavioral health parity compliance market conduct examination conducted and
597 completed under clause (ii) of subsection (a).

598 (f) The commissioner shall evaluate and resolve a consumer complaint alleging a
599 carrier's non-compliance with a state or federal law related to mental health and substance use
600 disorder parity, including any matters referred to the commissioner by the office of patient
601 protection under subsection (g) of section 14 of chapter 176O. A consumer complaint may be
602 submitted orally or in writing; provided, however, that an oral complaint shall be followed by a

603 written submission to the commissioner that shall include, but not be limited to, the
604 complainant's name and address, the nature of the complaint and the complainant's signature
605 authorizing the release of any information regarding the complaint to help the commissioner with
606 the review of the complaint; and provided further, that the commissioner shall create a process
607 for a consumer to request the appointment of an authorized representative to act on the
608 consumer's behalf.

609 The commissioner shall review consumer complaints under this subsection using the
610 legal standards pertaining to quantitative treatment limitations and nonquantitative treatment
611 limitations under applicable state and federal mental health and substance use disorder parity
612 laws, regulations and guidance, including, but not limited to, 45 CFR Part 146.136 and 29 C.F.R.
613 § 2590.712. When reviewing the complaint, the commissioner shall consider: (i) any related right
614 to a treatment or service under any related state or federal law or regulation; (ii) written
615 documents submitted by the complainant; (iii) medical records and medical opinions by the
616 complainant's treating provider that requested or provided a disputed service, which shall be
617 obtained by the complainant's carrier or by the commissioner if the carrier fails to do so; (iv) the
618 relevant results of any behavioral health parity compliance market conduct examination
619 conducted and completed under clause (ii) of subsection (a); (v) any relevant information
620 included in a carrier's annual reporting requirements under section 8M; (vi) additional
621 information from the involved parties or outside sources that the commissioner deems necessary
622 or relevant; and (vii) information obtained from any informal meeting held by the commissioner
623 with the parties. The commissioner shall send final written disposition of the complaint and the
624 reasons for the commissioner's decision to the complainant and the carrier not more than 90 days
625 after the receipt of the written complaint. If the commissioner determines that a violation of a

626 state or federal mental health and substance use disorder parity law occurred, the commissioner
627 shall exercise its enforcement authority under subsections (b) and (c).

628 The commissioner shall respond as soon as practicable to all questions or concerns from
629 consumers about carrier compliance with state or federal laws related to mental health and
630 substance use disorder parity that are referred to the commissioner from the office of patient
631 protection under subsection (g) of section 14 of chapter 176O.

632 (g) Nothing in this section shall limit the authority of the attorney general to enforce any
633 state or federal law, regulation or guidance described in this section.

634 (h) Nothing in this section shall prevent the commissioner from publishing any
635 illustrative utilization review criteria, medical necessity standard, clinical guideline or other
636 policy, procedure, criteria or standard, regardless of its origin, as an example of the type of
637 policy, procedure, criteria or standard that contributes to a violation of state or federal law parity
638 requirements, including any document that would normally be subject to disclosure to plan
639 members or their providers under section 16 of chapter 6D, section 16 of chapter 176O or the
640 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
641 2008, as amended.

642 SECTION 15. Said chapter 26 is hereby further amended by inserting after Section 8L
643 the following section:-

644 Section 8M. (a) All carriers licensed under chapters 175, 176A, 176B and 176G that
645 provide mental health or substance use disorder benefits, directly or through a behavioral health
646 manager, as defined in section 1 of chapter 176O, or any other entity that manages or administers

647 such benefits for the carrier, shall submit an annual report not later than July 1 to the
648 commissioner of insurance that contains:

649 (i) the specific plan or coverage terms or other relevant terms regarding the
650 nonquantitative treatment limitations and a description of all mental health and substance use
651 disorder benefits and medical and surgical benefits to which each term applies in each respective
652 benefits classification, provided, however, that the nonquantitative treatment limitations shall
653 include the processes, strategies, evidentiary standards or other factors used to develop and apply
654 the carrier's reimbursement rates for mental health and substance use disorder benefits and
655 medical and surgical benefits in each respective benefits classification;

656 (ii) the factors used to determine that the nonquantitative treatment limitations will apply
657 to mental health and substance use disorder benefits and medical and surgical benefits;

658 (iii) the evidentiary standards used for the factors identified in clause (ii), when
659 applicable, and any other source or evidence relied upon to design and apply the nonquantitative
660 treatment limitations to mental health and substance use disorder benefits and medical and
661 surgical benefits; provided, however, that every factor shall be defined;

662 (iv) a comparative analysis demonstrating that the processes, strategies, evidentiary
663 standards and other factors used to apply the nonquantitative treatment limitations to mental
664 health and substance use disorder benefits, as written and in operation, are comparable to, and
665 are applied no more stringently than, the processes, strategies, evidentiary standards and other
666 factors used to apply the nonquantitative treatment limitations to medical and surgical benefits in
667 the benefits classification;

668 (v) the specific findings and conclusions reached by the carrier with respect to health
669 insurance coverage, including any results of the analysis described in clause (iv) that indicate
670 whether the carrier is in compliance with this section and the federal Paul Wellstone and Pete
671 Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal
672 guidance or regulations relevant to the act, including, but not limited to, 45 CFR Part 146.136, 45
673 CFR Part 147.160 and 45 CFR Part 156.115(a)(3);

674 (vi) the number of requests for parity documents received under 29 CFR 2590.712(d)(3)
675 or 45 CFR 146.136(d)(3) and the number of any such requests for which the plan refused,
676 declined or was unable to provide documents;

677 (vii) the additional information, if any, that a carrier is required to provide under 42
678 U.S.C. 300gg-26(a)(8)(B)(ii); and

679 (viii) any other data or information the commissioner deems necessary to assess a
680 carrier's

681 compliance with mental health parity requirements.

682 (b) If federal guidance, including, but not limited to, the Self-Compliance Tool for the
683 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
684 2008, as amended, is released that indicates a nonquantitative treatment limitation analysis
685 process and reporting format that is significantly different from, contrary to or more efficient
686 than the nonquantitative treatment limitation analysis process and reporting format requirements
687 described in subsection (a), the commissioner may promulgate regulations that delineate a
688 nonquantitative treatment limitation analysis process and reporting format that may be used in

689 lieu of the nonquantitative treatment limitation analysis and reporting requirements described in
690 said subsection (a).

691 (c) Any proprietary portions of information submitted to the commissioner by a carrier as
692 a result of the requirements of this section shall not be a public record under clause Twenty-sixth
693 of section 7 of chapter 4 or chapter 66; provided, however, that: (i) the commissioner may
694 produce reports summarizing any findings; (ii) nothing in this section shall limit the authority of
695 the commissioner to use and, if appropriate, publish any final or preliminary examination report,
696 examiner or company work papers or other documents or other information discovered or
697 developed during the course of an examination in the furtherance of any legal or regulatory
698 action that the commissioner may, in their sole discretion, deem appropriate; and (iii) nothing in
699 this section shall prevent the commissioner of insurance from publishing any illustrative
700 utilization review criteria, medical necessity standard, clinical guideline or other policy,
701 procedure, criteria or standard, regardless of its origin, as an example of the type of policy,
702 procedure, criteria or standard that contributes to a violation of state or federal law parity
703 requirements, including any document that would normally be subject to disclosure to plan
704 members or their providers under section 16 of chapter 6D, section 16 of chapter 176O or under
705 the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
706 2008, as amended.

707 (d) Annually, not later than December 1, the commissioner shall submit a summary of the
708 reports that the commissioner receives from all carriers under subsection (a) to the clerks of the
709 senate and house of representatives, the joint committee on mental health, substance use and
710 recovery and the joint committee on health care financing; provided, that the summary shall
711 include, but not be limited to:

712 (i) the methodology the commissioner is using to check for compliance with the federal
713 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as
714 amended, and any federal guidance or regulations relevant to the act;

715 (ii) the methodology the commissioner is using to check for compliance with section 47B
716 of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and section 4M of
717 chapter 176G;

718 (iii) the report of each market conduct examination conducted or completed during the
719 immediately preceding calendar year regarding access to behavioral health services or
720 compliance with parity in mental health and substance use disorder benefits under state and
721 federal laws and any actions taken as a result of such market conduct examinations;

722 (iv) a breakdown of treatment authorization data for each carrier for mental health
723 treatment services, substance use disorder treatment services and medical and surgical treatment
724 services for the immediately preceding calendar year indicating for each treatment service: (A)
725 the number of inpatient days, outpatient services and total services requested; (B) the number
726 and per cent of inpatient day requests authorized, inpatient day requests modified, inpatient day
727 requests modified resulting in a lower amount of inpatient days authorized than requested and the
728 reason for the modification, inpatient day requests denied and the reason for the denial, inpatient
729 day requests where an internal appeal was filed and approved, inpatient day requests where an
730 internal appeal was filed and denied, inpatient day requests where an external appeal was filed
731 and upheld and inpatient day requests where an external appeal was filed and overturned; and
732 (C) the number and per cent of outpatient service requests authorized, outpatient service requests
733 modified, outpatient service requests modified resulting in a lower amount of outpatient service

734 authorized than requested and the reason for the modification, outpatient service requests denied
735 and the reason for the denial, outpatient service requests where an internal appeal was filed and
736 approved, outpatient service requests where an internal appeal was filed and denied, outpatient
737 service requests where an external appeal was filed and upheld and outpatient service requests
738 where an external appeal was filed and overturned;

739 (v) the number of consumer complaints received by the division of insurance under
740 subsection (f) of section 8K in the immediately preceding calendar year and a summary of all
741 such complaints resolved by the division during that time period, including: (A) the number of
742 complaints resolved in favor of the consumer; (B) the number of complaints resolved in favor of
743 the carrier; and (C) any enforcement actions taken in response to such complaints; and

744 (vi) information about any educational or corrective actions the commissioner has taken
745 to ensure carrier compliance with the federal Paul Wellstone and Pete Domenici Mental Health
746 Parity and Addiction Equity Act of 2008, as amended, and said section 47B of said chapter 175,
747 said section 8A of said chapter 176A, said section 4A of said chapter 176B and said section 4M
748 of said chapter 176G.

749 The summary report shall be written in nontechnical, readily understandable language
750 and made available to the public by posting the report on the division's website.

751 (e) The commissioner shall, upon receipt of an annual report submitted pursuant to
752 subsection (a), provide the annual report to the attorney general. The commissioner shall, upon
753 request by the attorney general, provide to the attorney general: (i) the comparative analyses and
754 related information described in 42 U.S.C. 300gg-26(a)(8)(A); and (ii) any findings that may be

755 shared with the commissioner pursuant to 42 U.S.C. 300gg-26(a)(8)(C)(iii), 29 U.S.C.
756 1185a(a)(8)(C)(iii) and 26 U.S.C. 9812(a)(8)(C)(iii).

757 SECTION 16. Chapter 32A of the General Laws is hereby amended by inserting after
758 section 17R the following section:-

759 Section 17S. (a) For the purposes of this section, the following terms shall have the
760 following meanings unless the context clearly requires otherwise:

761 “Community-based acute treatment”, 24-hour clinically managed mental health
762 diversionary or step-down services for children and adolescents that is usually provided as an
763 alternative to mental health acute treatment.

764 “Intensive community-based acute treatment”, intensive 24-hour clinically managed
765 mental health diversionary or step-down services for children and adolescents that is usually
766 provided as an alternative to mental health acute treatment.

767 “Mental health acute treatment”, 24-hour medically supervised mental health services
768 provided in an inpatient facility, licensed by the department of mental health, that provides
769 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
770 milieu.

771 (b) The commission shall provide to any active or retired employee of the commonwealth
772 who is insured under the group insurance commission coverage for medically necessary mental
773 health acute treatment, community-based acute treatment and intensive community-based acute
774 treatment and shall not require a preauthorization before obtaining treatment; provided, however,

775 that the facility shall notify the carrier of the admission and the initial treatment plan not more
776 than 72 hours after admission.

777 (c) Benefits for an employee under this section shall be the same for the employee's
778 covered spouse and covered dependents.

779 SECTION 17. Said chapter 32A is hereby further amended by inserting after section 22
780 the following 2 sections:-

781 Section 22A. For the purposes of this section, "psychiatric collaborative care model"
782 shall mean the evidence-based, integrated behavioral health service delivery method described in
783 81 FR 80230.

784 The commission shall provide to any active or retired employee of the commonwealth
785 who is insured under the group insurance commission coverage for mental health or substance
786 use disorder services that are delivered through the psychiatric collaborative care model.

787 Section 22B. (a) The commission shall implement and enforce the mental health parity
788 provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction
789 Equity Act of 2008, 42 U.S.C. 18031(j), as amended, federal guidance or regulations issued
790 under the act, applicable state mental health parity laws and regulations and, to the degree
791 applicable to its health benefit plans, guidance issued by the commissioner of insurance under
792 section 8K of chapter 26 by:

793 (i) utilizing the commission's procurement, contracting, vendor oversight and auditing
794 authority to ensure that the commission's health benefit plans that provide medical and surgical

795 benefits and mental health and substance use disorder benefits are compliant with the applicable
796 state or federal laws related to mental health and substance use disorder parity;

797 (ii) performing audits of each of the commission's health benefit plans at least once every
798 36 months, or more frequently if noncompliance is suspected, with a focus on: (A)
799 nonquantitative treatment limitations under the federal Paul Wellstone and Pete Domenici
800 Mental Health Parity and Addiction Equity Act of 2008, as amended, and applicable state mental
801 health and substance use disorder parity laws, including, but not limited to, prior authorization,
802 concurrent review, retrospective review, step-therapy, network admission standards,
803 reimbursement rates, network adequacy and geographic restrictions; (B) denials of authorization,
804 payment and coverage; and (C) any other criteria determined by the commission, including
805 factors identified through consumer or provider complaints;

806 (iii) requiring the commission's health benefit plans that provide medical and surgical
807 benefits and mental health and substance use disorder benefits to comply with the annual
808 reporting requirements under subsection (b); and

809 (iv) evaluating all consumer or provider complaints regarding mental health and
810 substance use disorder coverage for possible parity violations not more than 3 months after
811 receipt.

812 (b) The commission's health benefit plans that provide medical and surgical benefits and
813 mental health and substance use disorder benefits shall submit an annual report not later than
814 July 1 to the commission that contains:

815 (i) the specific plan or coverage terms or other relevant terms regarding the
816 nonquantitative treatment limitations and a description of all mental health and substance use

817 disorder benefits and medical and surgical benefits to which each term applies in each respective
818 benefits classification; provided, however, that the nonquantitative treatment limitations shall
819 include the processes, strategies, evidentiary standards or other factors used to develop and apply
820 the health benefit plan's reimbursement rates for mental health and substance use disorder
821 benefits and medical and surgical benefits in each respective benefits classification;

822 (ii) the factors used to determine that the nonquantitative treatment limitations will apply
823 to mental health and substance use disorder benefits and medical and surgical benefits;

824 (iii) the evidentiary standards used for the factors identified in clause (ii), when
825 applicable; provided, that every factor shall be defined, and any other source or evidence relied
826 upon to design and apply the nonquantitative treatment limitations to mental health and
827 substance use disorder benefits and medical and surgical benefits;

828 (iv) a comparative analysis demonstrating that the processes, strategies, evidentiary
829 standards and other factors used to apply the nonquantitative treatment limitations to mental
830 health and substance use disorder benefits, as written and in operation, are comparable to, and
831 are applied no more stringently than, the processes, strategies, evidentiary standards and other
832 factors used to apply the nonquantitative treatment limitations to medical or surgical benefits in
833 the benefits classification;

834 (v) the specific findings and conclusions reached by the health benefit plan with respect
835 to health insurance coverage, including any results of the analysis described in clause (iv) that
836 indicate whether the health benefit plan is in compliance with this section and the federal Paul
837 Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as
838 amended, and any federal guidance or regulations relevant to the act; and

839 (vi) any other data or information the commission deems necessary to assess a health
840 benefit plan's compliance with state or federal laws related to mental health and substance use
841 disorder parity.

842 (c) If federal guidance, including, but not limited to, the Self-Compliance Tool for the
843 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
844 2008, as amended, is released that indicates a nonquantitative treatment limitation analysis
845 process and reporting format that is significantly different from, contrary to or more efficient
846 than the nonquantitative treatment limitation analysis process and reporting format requirements
847 described in subsection (b), the commission may revise the analysis and reporting requirements
848 described in said subsection (b).

849 (d) Any proprietary portions of information submitted to the commission by a health
850 benefit plan as a result of the requirements of this section shall not be a public record under
851 clause Twenty-sixth of section 7 of chapter 4 or chapter 66; provided, however, that the
852 commission may produce reports summarizing any findings.

853 (e) Annually, not later than December 1, the commission shall submit a summary of the
854 reports that the commission receives from all health benefit plans under subsection (b) to the
855 clerks of the senate and house of representatives, the joint committee on mental health, substance
856 use and recovery and the joint committee on health care financing. The summary report shall
857 include, but not be limited to:

858 (i) the methodology the commission is using to check for compliance with the federal
859 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as
860 amended, and any federal guidance or regulations relevant to the act;

861 (ii) the methodology the commission is using to check for compliance with applicable
862 state mental health parity laws and regulations, including section 22 of chapter 32A, and, to the
863 degree applicable to its health benefit plans, guidance issued by the commissioner of insurance
864 under section 8K of chapter 26;

865 (iii) a summary of any audit findings for audits conducted and completed under clause (ii)
866 of subsection (a) during the immediately preceding calendar year regarding access to behavioral
867 health services or compliance with parity in mental health and substance use disorder benefits
868 under state and federal laws and any actions taken as a result of such audit; and

869 (iv) the number of consumer complaints the commission has received in the immediately
870 preceding calendar year regarding access to behavioral health services or compliance with parity
871 in mental health and substance use disorder benefits under state and federal laws and a summary
872 of all complaints resolved by the commission during that time period.

873 The summary report shall be written in nontechnical, readily understandable language
874 and made available to the public by posting the report on the commission's website.

875 SECTION 18. Said chapter 32A is hereby further amended by adding the following 2
876 sections:-

877 Section 31. The commission shall provide to any active or retired employee of the
878 commonwealth who is insured under the group insurance commission benefits on a
879 nondiscriminatory basis for medically necessary emergency services programs, as defined in
880 section 1 of chapter 175.

881 Section 32. (a) For the purpose of this section, the following words shall have the
882 following meanings:

883 “Licensed mental health professional”, a licensed physician who specializes in the
884 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a
885 licensed mental health counselor, a licensed supervised mental health counselor, a licensed nurse
886 mental health clinical specialist, a licensed physician assistant who practices in the area of
887 psychiatry, a licensed alcohol and drug counselor I, as defined in section 1 of chapter 111J, or a
888 licensed marriage and family therapist within the lawful scope of practice for such therapist.

889 “Mental health wellness examination”, a screening or assessment that seeks to identify
890 any behavioral or mental health needs and appropriate resources for treatment. The examination
891 may include: (i) observation, a behavioral health screening, education and consultation on
892 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
893 necessary supports and discussion of potential options for medication; and (ii) age-appropriate
894 screenings or observations to understand a covered person’s mental health history, personal
895 history and mental or cognitive state and, when appropriate, relevant adult input through
896 screenings, interviews and questions.

897 “Primary care provider”, a health care professional qualified to provide general medical
898 care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise
899 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
900 maintains continuity of care within the scope of practice.

901 (b) Any coverage offered by the commission to an active or retired employee of the
902 commonwealth insured under the group insurance commission shall provide coverage for an

903 annual mental health wellness examination that is performed by a licensed mental health
904 professional or primary care provider, which may be provided by the primary care provider as
905 part of an annual preventive visit. The examination shall be covered with no patient cost-
906 sharing.

907 SECTION 19. Section 25C½ of chapter 111 of the General Laws, as appearing in the
908 2020 Official Edition, is hereby amended by striking out, in line 28, the word “or”.

909 SECTION 20. Said section 25C½ of said chapter 111, as so appearing, is hereby further
910 amended by striking out, in line 39, the word “combination.” and inserting in place thereof the
911 following word:- combination;.

912 SECTION 21. Said section 25C½ of said chapter 111, as so appearing, is hereby further
913 amended by striking out, in line 56, the word “act.” and inserting in place thereof the following
914 words: act; or.

915 SECTION 22. Subsection (a) of said section 25C½ of said chapter 111, as so appearing,
916 is hereby amended by adding the following clause:-

917 (5) a health care facility if the health care facility plans to make a capital expenditure
918 solely for the development of acute psychiatric services, including inpatient, a crisis stabilization
919 unit, community-based acute treatment, intensive community-based acute treatment, a continuing
920 care unit or a partial hospitalization program; provided, however, that the health care facility
921 applying for the exemption demonstrates the need for a license from the department of mental
922 health pursuant to section 19 of chapter 19; provided further, that the department shall prioritize
923 exemptions for expenditures that provide services for certain high-need patient populations
924 including, but not limited to, children, individuals with autism spectrum disorder, intellectual

925 disabilities or developmental disabilities, individuals who present with a high-level of acuity
926 including severe behavior and assault risk, individuals with co-occurring substance use disorder,
927 individuals with co-occurring medical conditions, individuals with eating disorders and geriatric
928 patients; and provided further, that the department shall prioritize exemptions for expenditures
929 for services that would be located in underserved areas of the commonwealth.

930 SECTION 23. Said chapter 111 is hereby further amended by inserting after section 51½
931 the following section:-

932 Section 51¾. The department, in consultation with the department of mental health, shall
933 promulgate regulations requiring all acute-care hospitals licensed under section 51G to provide,
934 or arrange for, licensed mental health professionals during all operating hours of an emergency
935 department or a satellite emergency facility as defined in section 51½ to evaluate and stabilize a
936 person admitted with a mental health presentation to the emergency department or satellite
937 facility and to refer such person for appropriate treatment or inpatient admission. The regulations
938 shall define “licensed mental health professional”, which shall include, but not be limited to, a:
939 (i) licensed physician who specializes in the practice of psychiatry; (ii) licensed psychologist;
940 (iii) licensed independent clinical social worker; (iv) licensed certified social worker; (v) licensed
941 mental health counselor; (vi) licensed supervised mental health counselor; (vii) licensed
942 physician assistant who practices in the field of psychiatry (viii) licensed psychiatric clinical
943 nurse specialist; or (ix) healthcare provider, as defined in section 1, qualified within the scope of
944 the individual's license to conduct an evaluation of a mental health condition, including an intern,
945 resident or fellow pursuant to the policies and practices of the hospital and medical staff.

946 The regulations shall permit evaluation via telemedicine, electronic or telephonic
947 consultation, as deemed appropriate by the department.

948 The regulations shall be promulgated after consultation with the department of mental
949 health and the division of medical assistance and shall include, but not be limited to,
950 requirements that individuals under the age of 22 receive an expedited evaluation and
951 stabilization process.

952 SECTION 24. Section 232 of said chapter 111, as appearing in the 2020 Official Edition,
953 is hereby amended by striking out, in lines 12 and 13, the words “and (vii) a record of past
954 mental health treatment of the decedent” and inserting in place thereof the following words:-
955 “(vii) a record of past mental health treatment of the decedent; and (viii) the physical location of
956 the suicide, whether the location is private or public property and the number of known attempts
957 previously made by any other person at the same location.

958 SECTION 25. Section 80I of chapter 112, as so appearing, is hereby amended by
959 inserting after the word “practitioner”, in line 4, the following words:- or psychiatric nurse
960 mental health clinical specialist.

961 SECTION 26. Chapter 112 of the General Laws is hereby amended by inserting after
962 section 65F the following section:-

963 Section 65G. (a) As used in this section, the following words shall have the following
964 meanings unless the context clearly requires otherwise:

965 “Applicant”, a licensed health care professional who applies to participate in the program
966 in compliance with subsection (f).

967 “Board of registration”, a board of registration serving in the department pursuant to
968 section 9 of chapter 13 or under the supervision of the commissioner pursuant to section 1.

969 “Commissioner”, the commissioner of public health.

970 “Department”, the department of public health.

971 “License”, a license, registration, authorization or certificate issued by a board of
972 registration.

973 “Licensed health care professional”, an individual who holds a license.

974 “Licensing board”, a board of registration that has issued a license.

975 “Participant”, a licensed health care professional that has been admitted into the program
976 under this section.

977 “Program”, the voluntary program established by the department in paragraph (1) of
978 subsection (b).

979 “Record of participation”, the materials received and reviewed by the program’s director,
980 rehabilitation evaluation committee or a licensing board in connection with the application of a
981 licensed health care professional for admission into the program and in connection with the
982 progress of a participant during the program and compliance with an individualized rehabilitation
983 plan.

984 (b)(1) The department shall establish, within the bureau of health professions licensure, a
985 voluntary program for monitoring the rehabilitation of licensed health care professionals who
986 have a mental health diagnosis or substance use disorder.

987 (2) A board of registration that is required to establish a similar rehabilitation program by
988 another requirement of this chapter shall fulfill that requirement by formally adopting the
989 bureau's program in lieu of establishing its own.

990 (c)(1) There shall be an advisory committee to assist the department in the development
991 and implementation of the program. The committee shall consist of not less than the following
992 members or their designees: the commissioner, who shall serve as chair; the director of the
993 bureau of health professions licensure; and 9 persons to be appointed by the commissioner, 1 of
994 whom shall have expertise in the treatment of health professionals with a mental health diagnosis
995 or substance use disorder, 1 of whom shall be a representative of the Massachusetts Nurses
996 Association, 1 of whom shall be a representative of Local 509 Service Employees International
997 Union; 1 of whom shall be a representative of Local 1199 Service Employees International
998 Union, 1 of whom shall be a representative of the Massachusetts Chapter of the National
999 Association of Social Workers, Inc., 1 of whom shall be a representative of the Massachusetts
1000 Association of Physician Assistants, Inc., 1 of whom shall be a representative of the
1001 Massachusetts Dental Society, 1 of whom shall be a representative of the Massachusetts
1002 Pharmacists Association Foundation, Inc. and 1 of whom shall be a representative of the
1003 Massachusetts Health and Hospital Association, Inc.; provided, however, that the commissioner
1004 may appoint additional members as the commissioner determines necessary.

1005 (2) The committee shall: (i) review data, medical literature and expert opinions on the
1006 prevalence of mental health diagnoses and substance use disorders among licensed health
1007 professionals; (ii) make estimates regarding the number of licensed health professionals who
1008 could potentially benefit from participation in the program; (iii) examine the effectiveness of the
1009 rehabilitation program for registered pharmacists, pharmacy interns and pharmacy technicians

1010 established in section 24H and the rehabilitation program for nurses established in section 80F
1011 including, but not limited to, overall trends in enrollment, completion rates, failure rates,
1012 program design, eligibility criteria, application requirements, wait times for admissions, program
1013 duration, conditions of participation, penalties for noncompliance, privacy and confidentiality
1014 protections and return-to-work restrictions; (iv) identify best practices in voluntary, alternative-
1015 to-discipline rehabilitation programs that have been adopted in other states and any opportunities
1016 to modernize standards in the commonwealth; and (v) make recommendations to the department
1017 regarding eligibility criteria for admission into the program and the attributes necessary for the
1018 program to expand its access to licensed health care professionals, minimize stigma and other
1019 deterrents to participation, increase participation and completion rates, facilitate the successful
1020 return of participants to professional practice and enhance public health and safety, including,
1021 but not limited to, the size, scope and design of the program, the level of staffing and other
1022 resources necessary to adequately operate the program and protocols to ensure that the
1023 rehabilitation evaluation committee established in subsection (d) performs its duties in a timely
1024 fashion.

1025 (d)(1) There shall be a rehabilitation evaluation committee which shall consist of the
1026 following members to be appointed by the commissioner: 1 medical doctor or advanced practice
1027 registered nurse with experience in the treatment of mental health diagnoses or substance use
1028 disorders; 3 licensed health care professionals with demonstrated experience in the field of
1029 mental health or substance use disorders; 1 licensed health care professional in recovery from
1030 substance use disorder for not less than 5 years; and 2 persons who are or have been consumers
1031 of mental health or substance use disorder services. Three members of the committee shall
1032 constitute a quorum. The committee shall elect a chair and a vice chair from its membership.

1033 Members of the committee shall serve for terms of 4 years. No member shall be appointed or
1034 reappointed to the committee who is licensed to practice by a board of registration and has had
1035 any disciplinary or enforcement action taken against them by their respective licensing board
1036 during the 5 years preceding their appointment or reappointment to the committee. No current
1037 member of any board of registration shall serve on the committee. Meetings of the committee
1038 shall not be subject to sections 18 to 25, inclusive, of chapter 30A.

1039 (2) The rehabilitation evaluation committee shall: (i) receive and review information
1040 concerning participants in the program; (ii) evaluate licensed health care professionals who
1041 request to participate in the program and provide recommendations regarding the admission of
1042 such licensed health care professionals; (iii) review and designate treatment facilities and
1043 services to which participants may be referred; (iv) make recommendations for each participant
1044 as to whether the participant may continue or resume professional practice within the full scope
1045 of the participant's license; and (v) make recommendations for an individualized rehabilitation
1046 plan with requirements for supervision and surveillance for each participant.

1047 (e) The department shall employ a program director with demonstrated professional
1048 expertise in the field of mental health or substance use disorders to oversee participants in the
1049 rehabilitation program. The director shall: (i) admit eligible licensed health care professionals
1050 who request to participate in the program; (ii) receive and review information concerning
1051 participants in the program; (iii) provide each participant with an individualized rehabilitation
1052 plan with requirements for supervision and surveillance and update the plan as appropriate,
1053 taking into account the participant's compliance with the program and recommendations of the
1054 rehabilitation evaluation committee (iv) call meetings of the rehabilitation evaluation committee
1055 as necessary to review the requests of licensed health care professionals to participate in the

1056 program and review reports regarding participants; (v) serve as a liaison among the participant,
1057 the participant's licensing board, the rehabilitation evaluation committee and approved treatment
1058 programs and providers; (vi) terminate a participant from the program based on the participant's
1059 noncompliance with the participant's individualized rehabilitation plan or material
1060 misrepresentations by the participant concerning the participant's participation in the program or
1061 professional practice; (vii) provide information to licensed health care professionals who request
1062 to participate in the program; and (viii) report to the licensing board of an applicant or participant
1063 on: (A) an applicant's failure to complete the program's admission process; (B) a participant's
1064 admission into the program; (C): a participant's termination from the program; (D) a
1065 participant's withdrawal from the program before completion; and (E) the initial restrictions or
1066 conditions relating to a participant's professional practice incorporated into the participant's
1067 individualized rehabilitation plan and any changes or removal of the restrictions or conditions
1068 during the course of the participant's participation, and the basis for the restrictions or conditions
1069 and any changes to them; provided, however, that any restriction or condition relating to a
1070 participant's professional practice required under this subsection or any changes to a restriction
1071 or condition shall be subject to the approval by the participant's licensing board.

1072 (f) A licensed health care professional who applies to participate in the program shall
1073 acknowledge that they have a mental health diagnosis or substance use disorder that impacts
1074 their ability to safely practice their profession and shall agree to comply with an individualized
1075 rehabilitation plan to be admitted into the program. The program shall establish a form for such
1076 acknowledgement and agreement that the licensed health care professional shall complete and
1077 sign.

1078 (g) Upon admission of a licensed health care professional into the program, the licensing
1079 board may dismiss any pending investigation or complaint against the participant that arises from
1080 or relates to the participant’s mental health diagnosis or substance use disorder. The applicable
1081 licensing board may change the participant’s publicly-available license status to reflect the
1082 existence of nondisciplinary restrictions or conditions. The licensing board may immediately
1083 suspend the participant’s license as necessary to protect the public health, safety and welfare
1084 upon receipt of notice from the director that the participant has withdrawn from the program
1085 before completion or that the director has terminated the participant from the program.

1086 (h) The record of participation shall not be a public record and shall be exempt from
1087 disclosure pursuant to clause Twenty-sixth of section 7 of chapter 4 and chapter 66. If an
1088 applicant fails to complete the application process, a licensing board may use information and
1089 documents in the record of participation as evidence in a disciplinary proceeding as necessary to
1090 protect public health, safety and welfare. In all other instances, the record of participation shall
1091 not be subject to subpoena or discovery in any civil, criminal, legislative or administrative
1092 proceeding without the prior written consent of the participant. The records of participation of
1093 participants who successfully complete the program shall be destroyed 3 years following the date
1094 of successful completion.

1095 SECTION 27. Section 130 of chapter 112 of the General Laws, as appearing in the 2020
1096 Official Edition, is hereby amended by striking out the definition of “The independent practice of
1097 clinical social work” and inserting in place thereof the following definition:-

1098 “Clinical social work practice”, social work performed by master's level social workers
1099 applying evidence-informed theories and methods in the comprehensive assessment and

1100 treatment of cognitive, affective and behavioral disorders and distress arising from physical,
1101 environmental, psychological, emotional or relational conditions; provided, however, that the
1102 scope of clinical social work practice shall include, but not be limited to: (i) assessment,
1103 evaluation, psychotherapy and counseling for individuals, families, and groups; (ii) client-
1104 centered advocacy, consultation and supervision; and (iii) case management services; provided
1105 further, that the practice of clinical social workers shall be within an ecological and ethically-
1106 principled framework in the areas of competence that their education and training reflects; and
1107 provided further, that “clinical social work practice” shall be multi-systemic, trauma-informed
1108 and committed to public health and well-being.

1109 SECTION 28. Section 133 of said chapter 112, as so appearing, is hereby amended by
1110 striking out, in lines 8 and 9, the words “the independent practice of clinical social work” and
1111 inserting in place thereof the following words:- clinical social work practice.

1112 SECTION 29. Section 163 of said chapter 112, as so appearing, is hereby amended by
1113 inserting after the definition of “Licensed mental health counselor” the following definition:-

1114 “Licensed supervised mental health counselor”, a person licensed or eligible for license
1115 under section 165.

1116 SECTION 30. Section 164 of said chapter 112, as so appearing, is hereby amended by
1117 inserting after the word “consultant”, in line 7, the following words:- or licensed supervised
1118 mental health counselor, advisor or consultant.

1119 SECTION 31. Section 165 of said chapter 112, as so appearing, is hereby amended by
1120 inserting after the word “health”, in line 16, the following words:- or the department of public
1121 health.

1122 SECTION 32. Said section 165 of said chapter 112, as so appearing, is hereby further
1123 amended by adding the following 3 paragraphs:-

1124 The board may issue a license to an applicant as a supervised mental health counselor;
1125 provided, however, that each applicant, in addition to complying with clauses (1) and (2) of the
1126 first paragraph, shall provide satisfactory evidence to the board that the applicant: (i)
1127 demonstrates to the board the successful completion of a master's degree in a relevant field from
1128 an educational institution licensed by the state in which it is located and meets national standards
1129 for granting of a master's degree with a sub-specialization in counseling or a relevant sub-
1130 specialization approved by the board; and (ii) has successfully passed a board-approved
1131 examination.

1132 A supervised mental health counselor shall practice under supervision of a clinician in a
1133 clinic or hospital licensed by the department of mental health or the department of public health
1134 or accredited by the Joint Commission on Accreditation of Hospitals or in an equivalent center or
1135 institute or under the direction of a supervisor approved by the board.

1136 The board shall promulgate rules and regulations specifying the required qualifications of
1137 the supervising clinician.

1138 SECTION 33. Chapter 118E of the General Laws is hereby amended by inserting after
1139 section 10N the following 3 sections:-

1140 Section 10O. For the purposes of this section, the following terms shall have the
1141 following meanings unless the context clearly requires otherwise:-

1142 “Community-based acute treatment”, 24-hour clinically managed mental health
1143 diversionary or step-down services for children and adolescents that is usually provided as an
1144 alternative to mental health acute treatment.

1145 “Intensive community-based acute treatment”, intensive 24-hour clinically managed
1146 mental health diversionary or step-down services for children and adolescents that is usually
1147 provided as an alternative to mental health acute treatment.

1148 “Mental health acute treatment”, 24-hour medically supervised mental health services
1149 provided in an inpatient facility, licensed by the department of mental health, that provides
1150 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
1151 milieu.

1152 The division and its contracted health insurers, health plans, health maintenance
1153 organizations, behavioral health management firms and third-party administrators under contract
1154 to a Medicaid managed care organization or primary care clinician plan shall cover the cost of
1155 medically necessary mental health acute treatment, community-based acute treatment and
1156 intensive community-based acute treatment and shall not require a preauthorization before
1157 obtaining treatment; provided, however, that the facility shall notify the carrier of the admission
1158 and the initial treatment plan within 72 hours of admission.

1159 Section 10P. For the purposes of this section, “psychiatric collaborative care model” shall
1160 mean the evidence-based, integrated behavioral health service delivery method described in 81
1161 FR 80230.

1162 The division and its contracted health insurers, health plans, health maintenance
1163 organizations, behavioral health management firms and third-party administrators under contract

1164 to a Medicaid managed care organization or primary care clinician plan shall provide coverage
1165 for mental health or substance use disorder services that are delivered through the psychiatric
1166 collaborative care model.

1167 Section 10Q. (a) For the purpose of this section, the following words shall have the
1168 following meanings:

1169 “Licensed mental health professional”, a licensed physician who specializes in the
1170 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a
1171 licensed mental health counselor, a licensed supervised mental health counselor, a licensed nurse
1172 mental health clinical specialist, a licensed physician assistant who practices in the area of
1173 psychiatry, a licensed alcohol and drug counselor I, as defined in section 1 of chapter 111J, or a
1174 licensed marriage and family therapist within the lawful scope of practice for such therapist.

1175 “Mental health wellness examination”, a screening or assessment that seeks to identify
1176 any behavioral or mental health needs and appropriate resources for treatment. The examination
1177 may include: (i) observation, a behavioral health screening, education and consultation on
1178 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
1179 necessary supports and discussion of potential options for medication; and (ii) age-appropriate
1180 screenings or observations to understand a covered person’s mental health history, personal
1181 history and mental or cognitive state and, when appropriate, relevant adult input through
1182 screenings, interviews and questions.

1183 “Primary care provider”, a health care professional qualified to provide general medical
1184 care for common health care problems who: (i) supervises, coordinates, prescribes or otherwise

1185 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
1186 maintains continuity of care within the scope of practice.

1187 (b) The division shall provide coverage for an annual mental health wellness examination
1188 that is performed by a licensed mental health professional or primary care provider, which may
1189 be provided by the primary care provider as part of an annual preventive visit. The examination
1190 shall be covered with no patient cost-sharing.

1191 SECTION 34. Said chapter 118E is hereby further amended by inserting after section
1192 13D the following section:-

1193 Section 13D½. (a) For the purposes of this section, the following words shall have the
1194 following meanings unless the context clearly requires otherwise:

1195 “Behavioral health services”, the evaluation, diagnosis, treatment, care coordination,
1196 management or peer support of patients with mental health, developmental or substance use
1197 disorders.

1198 “Community behavioral health center”, a clinic licensed by the department of public
1199 health pursuant to section 3 and sections 51 to 56, inclusive, of chapter 111.

1200 “Division”, the division of medical assistance.

1201 “Managed care entity”, health insurers, health plans, health maintenance organizations,
1202 behavioral health management firms and third party administrators under contract with a
1203 Medicaid managed care organization or primary care clinician plan; provided, however, that
1204 “managed care entity” shall also include accountable care organizations.

1205 “Minimum payment rates”, rates of payment for services below which managed care
1206 entities shall not enter into provider agreements.

1207 (b) Annually, not later than January 1, the division shall review the minimum payment
1208 rates to be paid to providers of behavioral health services delivered in community behavioral
1209 health centers by managed care entities and submit a report to the house and senate committees
1210 on ways and means, the joint committee on health care financing and the joint committee on
1211 mental health, substance use and recovery identifying the difference between the minimum
1212 payment rates decided by the division and the payment rates that managed care entities
1213 contractually agree to pay providers for all behavioral health services delivered in community
1214 behavioral health centers.

1215 SECTION 35. Section 47 of said chapter 118E, as appearing in the 2020 Official Edition,
1216 is hereby amended by inserting after the first paragraph the following paragraph:-

1217 Notwithstanding any general or special law to the contrary, the division shall promulgate
1218 regulations that require the division, its contracted health insurers, health plans, health
1219 maintenance organizations, behavioral health management firms and third-party administrators
1220 under contract with the division, a Medicaid managed care organization or primary care clinician
1221 plan, to maintain documentation of all requests for benefits or services, whether the request is
1222 submitted by, or on behalf of, the intended recipient of those benefits or services. Any request
1223 that is not fulfilled in full shall be considered a denial and shall result in the prompt written
1224 notification to the intended recipient through electronic means, if possible. The notification shall
1225 include a description of the requested service, the response by the entity and the intended

1226 recipient's due process and appeal rights. All such entities shall accept requests for authorized
1227 representatives or for appeals by electronic means.

1228 SECTION 36. Said chapter 118E is hereby further amended by adding the following 4
1229 sections:-

1230 Section 80. (a) The division, its managed care organizations, accountable care
1231 organizations or other entity contracting with the division to manage or administer mental health
1232 and substance use disorder benefits shall ensure that there are no separate non-quantitative
1233 treatment limitations that apply to mental health and substance use disorder benefits but do not
1234 apply to medical and surgical benefits within any classification of benefits as defined under the
1235 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
1236 2008, as amended, and applicable state mental health parity laws, including, but not limited to,
1237 section 81; provided, however, that the non-quantitative treatment limitations shall include the
1238 processes, strategies or methodologies for developing and applying the division's reimbursement
1239 rates for mental health and substance use disorder benefits and medical and surgical benefits
1240 within each classification of benefits.

1241 (b) The division shall perform a behavioral health parity compliance examination of each
1242 Medicaid managed care organization, accountable care organization or other entity contracted
1243 with the agency that manages or administers mental health and substance use disorder benefits
1244 for the division at least once every 36 months. The examination shall include examination of
1245 entities that manage medical and surgical benefits, as necessary. The examination shall only
1246 apply where the division is the primary payer. The examination shall include, but not be limited
1247 to:

1248 (i) non-quantitative treatment limitations, including, but not limited to, prior
1249 authorization, concurrent review, retrospective review, step-therapy, network admission
1250 standards, reimbursement rates and geographic restrictions;

1251 (ii) approvals and denials of authorization, payment and coverage; and

1252 (iii) any other specific criteria as may be determined by the division, including factors
1253 identified through consumer or provider complaints.

1254 (c) The division shall require each of its managed care organizations, accountable care
1255 organizations or other entity contracting with the division to manage or administer mental health
1256 and substance use disorder benefits to submit an annual report to the division on or before July 1
1257 that shall include:

1258 (i) the specific plan or coverage terms or other relevant terms regarding the non-
1259 quantitative treatment limitations and a description of all mental health and substance use
1260 disorder benefits and medical and surgical benefits to which each term applies in each respective
1261 benefits classification; provided, however, that the non-quantitative treatment limitations shall
1262 include the processes, strategies, evidentiary standards or other factors used to develop and apply
1263 the entity's reimbursement rates for mental health and substance use disorder benefits and
1264 medical and surgical benefits in each respective benefits classification;

1265 (ii) the factors used to determine that the non-quantitative treatment limitations will apply
1266 to mental health and substance use disorder benefits and medical and surgical benefits;

1267 (iii) the evidentiary standards used to define the factors identified in clause (ii), when
1268 applicable; provided, however, that every factor shall be defined and any other source or

1269 evidence relied upon to design and apply the non-quantitative treatment limitations to mental
1270 health and substance use disorder benefits and medical and surgical benefits;

1271 (iv) a comparative analyses demonstrating that the processes, strategies, evidentiary
1272 standard and other factors used to apply the non-quantitative treatment limitations to mental
1273 health and substance use disorder benefits, as written and in operation, are comparable to and are
1274 applied no more stringently than the processes, strategies, evidentiary standards and other factors
1275 used to apply the non-quantitative treatment limitations to medical and surgical benefits in the
1276 benefits classification;

1277 (v) the specific findings and conclusions reached by the entity with respect to health
1278 insurance coverage, including any results of the analysis described in clause (iv) that indicates
1279 whether the entity is in compliance with this section and the federal Paul Wellstone and Pete
1280 Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and federal
1281 guidelines and regulations relevant to the act, including, but not limited to, 42 CFR Part 457.496;

1282 (vi) the treatment authorization data for the prior calendar year, which shall include, but
1283 not be limited to: (A) the number of inpatient days, outpatient services and total number of
1284 services requested; (B) the number and per cent of inpatient day requests authorized, inpatient
1285 day requests modified, inpatient day requests modified resulting in a lesser amount of inpatient
1286 days authorized than requested and the reason for the modification, inpatient day requests denied
1287 and the reason for the denial, inpatient day requests where an internal appeal was filed and
1288 approved, inpatient day requests where an internal appeal was filed and denied, inpatient day
1289 requests where an external appeal was filed and upheld and inpatient day requests where an
1290 external appeal was filed and overturned; and (C) the number and per cent of outpatient service

1291 requests authorized, outpatient service requests modified, outpatient service requests modified
1292 resulting in a lower amount of outpatient service authorized than requested and the reason for the
1293 modification, outpatient service requests denied and the reason for the denial, outpatient service
1294 requests where an internal appeal was filed and approved, outpatient service requests where an
1295 internal appeal was filed and denied, outpatient service requests where an external appeal or
1296 hearing before the board of hearings was filed and upheld and outpatient service requests where
1297 an external appeal was filed and overturned;

1298 (vii) the additional information, if any, that an entity is required to provide under 42
1299 U.S.C. 300gg-26(a)(8)(B)(ii); and

1300 (viii) any other data or information the division deems necessary to assess an entity's
1301 compliance with mental health parity requirements.

1302 (d) If federal guidance, including, but not limited to, the Self-Compliance Tool for the
1303 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
1304 2008, as amended, is released that indicates a non-quantitative treatment limitation analysis
1305 process and reporting format that is significantly different from, contrary to or more efficient
1306 than the non-quantitative treatment limitation analysis process and reporting format requirements
1307 described in subsection (b), the division may promulgate regulations that delineate a non-
1308 quantitative treatment limitation analysis process and reporting format that may be used in lieu of
1309 the non-quantitative treatment limitation analysis and reporting requirements described in said
1310 subsection (b).

1311 (e) Any proprietary information submitted to the general court by the division as a result
1312 of the requirements in this section shall not be a public record under clause Twenty-sixth of

1313 section 7 of chapter 4 or chapter 66; provided, however, that nothing in this section shall limit
1314 the authority of the director of Medicaid to use and, if appropriate, publish any final or
1315 preliminary examination report, examiner or company work papers or other documents or other
1316 information discovered or developed during the course of an examination in the furtherance of
1317 any legal or regulatory action that the director may, in their sole discretion, deem appropriate;
1318 provided further, that nothing in this section shall prevent the director of Medicaid from
1319 publishing any illustrative utilization review criteria, medical necessity standard, clinical
1320 guideline or other policy, procedure, criteria or standard, regardless of its origin, as an example
1321 of the type of policy, procedure, criteria or standard that contributes to a violation of state or
1322 federal law parity requirements, including any information that is subject to disclosure to plan
1323 members under the federal Paul Wellstone and Pete Domenici Mental Health Parity and
1324 Addiction Equity Act of 2008, as amended, or under any member right to receive such guideline
1325 under applicable federal law.

1326 (f) Annually, not later than December 1, the division shall submit a summary of the
1327 reports that the division receives from all entities under subsection (c) to the clerks of the senate
1328 and house of representatives, the joint committee on mental health, substance use and recovery
1329 and the joint committee on health care financing. The summary report shall include, but not be
1330 limited to:

1331 (i) the methodology the division is using to check for compliance with the federal Paul
1332 Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as
1333 amended, and any federal regulations or guidance relevant to the act;

1334 (ii) the methodology the division is using to check for compliance with section 81;

1335 (iii) the report of each examination conducted or completed under subsection (b) during
1336 the immediately preceding calendar year regarding access to behavioral health services or
1337 compliance with parity in mental health and substance use disorder benefits under state and
1338 federal laws and any actions taken as a result of such examinations;

1339 (iv) a breakdown of treatment authorization data for the division, and for each Medicaid
1340 managed care organization, accountable care organization or other entity that manages or
1341 administers benefits for the division, for mental health treatment services, substance use disorder
1342 treatment services and medical and surgical treatment services for the immediately preceding
1343 calendar year indicating for each treatment service: (A) the number of inpatient days, outpatient
1344 services and total number of services requested; (B) the number and per cent of inpatient day
1345 requests authorized, inpatient day requests modified, inpatient day requests modified resulting in
1346 a lesser amount of inpatient days authorized than requested and the reason for the modification,
1347 inpatient day requests denied and the reason for the denial, inpatient day requests where an
1348 internal appeal was filed and approved, inpatient day requests where an internal appeal was filed
1349 and denied, inpatient day requests where an external review under section 47B or hearing before
1350 the board of hearings under section 48 was filed and upheld and inpatient day requests where an
1351 external review under said section 47B or hearing before the board of hearings under said section
1352 48 was filed and overturned; and (C) the number and per cent of outpatient service requests
1353 authorized, outpatient service requests modified, outpatient service requests modified resulting in
1354 a lower amount of outpatient service authorized than requested and the reason for the
1355 modification, outpatient service requests denied and the reason for the denial, outpatient service
1356 requests where an internal appeal was filed and approved, outpatient service requests where an
1357 internal appeal was filed and denied, outpatient service requests where an external review under

1358 said section 47B or hearing before the board of hearings under said section 48 was filed and
1359 upheld and outpatient service requests where an external review under said section 47B or
1360 hearing before the board of hearings under said section 48 was filed and overturned;

1361 (v) the number of complaints the division, or any Medicaid managed care organization,
1362 accountable care organization or other entity contracting with the division to manage or
1363 administer mental health and substance use disorder benefits, has received in the immediately
1364 preceding calendar year regarding access to behavioral health services or compliance with parity
1365 in mental health and substance use disorder benefits under state and federal laws and a summary
1366 of all complaints resolved by the division, or any Medicaid managed care organization,
1367 accountable care organization or other entity contracting with the division to manage or
1368 administer mental health and substance use disorder benefits, during that time period; and

1369 (vi) information about any educational or corrective actions the division has taken to
1370 ensure carrier compliance with the federal Paul Wellstone and Pete Domenici Mental Health
1371 Parity and Addiction Equity Act of 2008, as amended, and section 81.

1372 The summary report shall be written in non-technical, readily understandable language
1373 and shall be made publicly available on the division's website.

1374 (g) The division shall evaluate all consumer or provider complaints regarding mental
1375 health and substance use disorder coverage for possible parity violations within 3 months of
1376 receipt of the complaint.

1377 Section 81. (a) The division and its health insurers, health plans, health maintenance
1378 organizations, behavioral health management firms and third-party administrators under contract
1379 with the division, a Medicaid managed care organization or a primary care clinician plan shall

1380 provide mental health and substance use disorder benefits for the diagnosis and medically-
1381 necessary treatment of any behavioral health disorder described in the most recent edition of the
1382 Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric
1383 Association or the most current version of the International Classification of Diseases. The
1384 benefits shall be provided on a nondiscriminatory basis.

1385 (b) In addition to the mental health and substance use disorder benefits established
1386 pursuant to this section, the division shall provide benefits on a non-discriminatory basis for
1387 children and adolescents under the age of 19 for the diagnosis and treatment of mental,
1388 behavioral, emotional or substance use disorders described in the most recent edition of the
1389 Diagnostic and Statistical Manual of Mental Disorders that substantially interfere with or
1390 substantially limit the functioning and social interactions of such a child or adolescent; provided,
1391 however, that the interference or limitation is documented by and the referral for the diagnosis
1392 and treatment is made by the primary care provider, primary pediatrician or a licensed mental
1393 health professional of such a child or adolescent or is evidenced by conduct including, but not
1394 limited to: (i) an inability to attend school as a result of such a disorder; (ii) the need to
1395 hospitalize the child or adolescent as a result of such a disorder; or (iii) a pattern of conduct or
1396 behavior caused by such a disorder that poses a serious danger to oneself or others.

1397 (c) For the purposes of this section, the division shall be deemed to be providing such
1398 coverage on a non-discriminatory basis if the plan or coverage does not contain any annual or
1399 lifetime dollar or unit of service limitation on coverage for the diagnosis and treatment of the
1400 mental disorders that is less than any annual or lifetime dollar or unit of service limitation
1401 imposed on coverage for the diagnosis and treatment of physical conditions.

1402 (d) Benefits authorized pursuant to this section shall consist of a range of inpatient,
1403 intermediate and outpatient services that shall permit medically-necessary, active and
1404 noncustodial treatment for the mental disorders to take place in the least restrictive clinically
1405 appropriate setting. For purposes of this section, inpatient services may be provided in a general
1406 hospital licensed to provide such services, in a facility under the direction and supervision of the
1407 department of mental health, in a private mental hospital licensed by the department of mental
1408 health or in a substance abuse facility licensed by the department of public health. Intermediate
1409 services shall include, but not be limited to, Level III community-based detoxification, acute
1410 residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or
1411 approved by the department of public health or the department of mental health. Outpatient
1412 services may be provided in a licensed hospital, a mental health or substance abuse clinic
1413 licensed by the department of public health, a public community mental health center, a
1414 professional office or as home-based services.

1415 (e) The division and its health insurers, health plans, health maintenance organizations,
1416 behavioral health management firms and third-party administrators under contract with the
1417 division, a Medicaid managed care organization or a primary care clinician plan shall not require,
1418 as a condition of receiving benefits mandated by this section, consent to the disclosure of
1419 information regarding services for mental disorders under different terms and conditions than
1420 consent is required for disclosure of information for other medical conditions. A determination
1421 by the division or its agents that services authorized pursuant to this section are not medically
1422 necessary shall only be made by a mental health professional licensed in the appropriate
1423 specialty related to such services and, where applicable, by a provider in the same licensure
1424 category as the ordering provider; provided, however, that this subsection shall not apply to

1425 denials of service resulting from an enrollee's lack of coverage or use of a facility or professional
1426 that has not entered into a negotiated agreement with the division or its agents. The benefits
1427 provided by the division or its agents pursuant to this section shall meet all other terms and
1428 conditions of the plan consistent with state or federal law.

1429 (f) Nothing in this section shall require the division to pay for mental health or substance
1430 use disorder benefits or services that:

1431 (i) are otherwise covered by third-party insurance;

1432 (ii) are provided to a person who is presently incarcerated, confined or committed to a
1433 jail, house of correction or prison;

1434 (iii) constitute educational services required to be provided by a school committee
1435 pursuant to section 5 of chapter 71B;

1436 (iv) constitute services provided by the department of mental health, the department of
1437 public health or the department of developmental services; or

1438 (v) are not eligible for federal financial participation.

1439 Section 82. Notwithstanding any general or special law to the contrary, the office of
1440 Medicaid shall seek a waiver and promulgate regulations in order to require the division and its
1441 health insurers, health plans, health maintenance organizations, behavioral health management
1442 firms and third-party administrators under contract with the division, a Medicaid managed care
1443 organization or primary care clinician plan to meet the parity requirements described under the
1444 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
1445 2008, as amended, and any federal guidance or regulations relevant to the act, including 42 CFR

1446 438 Subpart K, 42 CFR 440.395 and 42 CFR 457.496, for all enrollees. For persons under the
1447 age of 21, MassHealth and its agents may comply with this section by meeting the obligations
1448 related to Early and Periodic Screening, Diagnostic and Treatment benefits under 42 CFR
1449 457.496(b) or 440.395(c).

1450 Section 83. Medical necessity and utilization management determinations for treatments
1451 for substance use disorder or co-occurring mental illness and substance use disorder authorized
1452 under this chapter shall be made in accordance with the criteria established by the American
1453 Society of Addiction Medicine. No additional criteria may be used to make medical necessity or
1454 utilization management determinations for treatments for substance use disorder or co-occurring
1455 mental illness and substance use disorder, unless such criteria are less restrictive than those
1456 established by the American Society of Addiction Medicine. Authorization or coverage for
1457 treatment for substance use disorder or co-occurring mental illness and substance use disorder
1458 shall not be denied by the division, or a Medicaid managed care organization, accountable care
1459 organization or other entity that manages or administers mental health and substance use disorder
1460 benefits for the division, on the basis that such treatment was authorized or ordered by a court of
1461 law or other law enforcement agency. Any such authorization or order for such services shall be
1462 considered a factor in support of coverage for such treatment.

1463 SECTION 37. Chapter 123 of the General Laws is hereby amended by inserting after
1464 section 2 the following section:-

1465 Section 2A. When promulgating regulations governing the contracting for services, the
1466 department shall establish within its regulations additional factors to be considered when

1467 contracting for services in geographically-isolated communities, including, but not limited to,
1468 travel and transportation, to ensure availability and access to services.

1469 SECTION 38. Section 18 of said chapter 123, as appearing in the 2020 Official Edition,
1470 is hereby amended by striking out, in lines 27 to 34, inclusive, the words “; provided, however,
1471 that, notwithstanding the court’s failure, after an initial hearing or after any subsequent hearing,
1472 to make a finding required for commitment to the Bridgewater state hospital, the prisoner shall
1473 be confined at said hospital if the findings required for commitment to a facility are made and if
1474 the commissioner of correction certifies to the court that confinement of the prisoner at the
1475 hospital is necessary to insure his continued retention in custody.

1476 SECTION 39. Said section 18 of said chapter 123, as so appearing, is hereby further
1477 amended by inserting after subsection (a) the following subsection:-

1478 (a ½) (1) For purposes of this subsection, “mental health watch” shall mean a status
1479 intended to protect a prisoner from a risk of imminent and serious self-harm.

1480 (2) A prisoner or a prisoner’s legal representative, or a mental health staff person by
1481 request of a prisoner, may petition to the district court that has jurisdiction over the prisoner’s
1482 place of detention or, if the prisoner is awaiting trial, to the court that has jurisdiction of the
1483 criminal case to be transferred to a suitable inpatient psychiatric facility or unit licensed or
1484 operated by the department of mental health or to Bridgewater state hospital. The court may
1485 order the prisoner’s requested transfer if the prisoner: (i) has been on mental health watch for at
1486 least 24 hours; or (ii) is at serious risk of imminent and serious self-harm. A transfer ordered
1487 under this subsection shall only be ordered to Bridgewater state hospital if: (i) the prisoner is
1488 male and no bed is available in a timely manner at a unit licensed or operated by the department

1489 of mental health; or (ii) (A) the prisoner is not a proper subject for commitment to an inpatient
1490 psychiatric facility or unit licensed or operated by the department of mental health; and (B) the
1491 failure to retain the prisoner in strict custody would create a likelihood of serious harm. When a
1492 prisoner has been on mental health watch for 24 hours, and once every 24 hours thereafter that
1493 the prisoner remains on mental health watch, a member of the mental health staff of the place of
1494 detention shall advise the prisoner of the prisoner's right to petition under this subsection and ask
1495 the prisoner if the prisoner would like a mental health staff person to petition on the prisoner's
1496 behalf. If the prisoner requests, either orally or in writing, that a mental health staff person
1497 petition under this subsection, a mental health staff person shall file a petition with the
1498 appropriate court within 8 hours. If a prisoner, a prisoner's legal representative or a mental health
1499 staff person files a petition in a court that lacks jurisdiction under this subsection, the clerk of the
1500 court shall, as soon as is practicable, determine the court with jurisdiction and forward the
1501 petition to that court for adjudication. The court may order periodic reviews of transfers under
1502 this subsection.

1503 SECTION 40. Section 1 of chapter 175 of the General Laws, as so appearing, is hereby
1504 amended by inserting after the definition of "Domestic company" the following definition:-

1505 "Emergency services programs", all programs subject to contract between the
1506 Massachusetts Behavioral Health Partnership and nonprofit organizations for the provision of
1507 community-based emergency psychiatric services, including, but not limited to, behavioral
1508 health crisis assessment, intervention and stabilization services 24 hours per day, 7 days per
1509 week, through: (i) mobile crisis intervention services for youth; (ii) mobile crisis intervention
1510 services for adults; (iii) emergency service provider community-based locations; and (iv) adult
1511 community crisis stabilization services.

1512 SECTION 41. Section 47B of said chapter 175, as so appearing, is hereby amended by
1513 inserting after the word “specialist”, in line 122, the following words:-, a clinician practicing
1514 under the supervision of a licensed professional and working towards licensure in a clinic
1515 licensed under chapter 111.

1516 SECTION 42. Said chapter 175 is hereby further amended by inserting after section
1517 47PP, the following 4 sections:-

1518 Section 47QQ. For the purposes of this section, “psychiatric collaborative care model”
1519 shall mean the evidence-based, integrated behavioral health service delivery method described in
1520 81 FR 80230.

1521 An individual policy of accident and sickness insurance issued pursuant to section 108
1522 that provides hospital expense and surgical expense insurance or a group blanket or general
1523 policy of accident and sickness insurance issued pursuant to section 110 that provides hospital
1524 expense and surgical expense insurance that is issued or renewed within or without the
1525 commonwealth shall provide coverage for mental health or substance use disorder services that
1526 are delivered through the psychiatric collaborative care model.

1527 Section 47RR. An individual policy of accident and sickness insurance issued under
1528 section 108 that provides hospital expense and surgical expense insurance or a group blanket or
1529 general policy of accident and sickness insurance issued under section 110 that provides hospital
1530 expense and surgical expense insurance that is issued or renewed within or without the
1531 commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary
1532 emergency services programs.

1533 Section 47SS. (a) For the purposes of this section, the following terms shall have the
1534 following meanings unless the context clearly requires otherwise:

1535 “Community-based acute treatment”, 24-hour clinically managed mental health
1536 diversionary or step-down services for children and adolescents that is usually provided as an
1537 alternative to mental health acute treatment.

1538 “Intensive community-based acute treatment”, intensive 24-hour clinically managed
1539 mental health diversionary or step-down services for children and adolescents that is usually
1540 provided as an alternative to mental health acute treatment.

1541 “Mental health acute treatment”, 24-hour medically supervised mental health services
1542 provided in an inpatient facility licensed by the department of mental health that provides
1543 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
1544 milieu.

1545 (b) A policy, contract, agreement, plan or certificate of insurance issued, delivered or
1546 renewed within or without the commonwealth, which is considered creditable coverage under
1547 section 1 of chapter 111M, shall provide coverage for medically necessary mental health acute
1548 treatment, community-based acute treatment and intensive community-based acute treatment and
1549 shall not require a preauthorization before the administration of such treatment; provided,
1550 however, that the facility shall notify the carrier of the admission and the initial treatment plan
1551 within 72 hours of admission.

1552 Section 47TT. (a) For the purpose of this section, the following words shall have the
1553 following meanings unless the context clearly requires otherwise:

1554 “Licensed mental health professional,” a licensed physician who specializes in the
1555 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a
1556 licensed mental health counselor, a licensed supervised mental health counselor, a licensed nurse
1557 mental health clinical specialist, a licensed physician assistant who practices in the area of
1558 psychiatry, a licensed alcohol and drug counselor I, as defined in section 1 of chapter 111J or a
1559 licensed marriage and family therapist within the lawful scope of practice for such therapist.

1560 “Mental health wellness examination,” a screening or assessment that seeks to identify
1561 any behavioral or mental health needs and appropriate resources for treatment. The examination
1562 may include: (i) observation, a behavioral health screening, education and consultation on
1563 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
1564 necessary supports and discussion of potential options for medication; and (ii) age-appropriate
1565 screenings or observations to understand a covered person’s mental health history, personal
1566 history and mental or cognitive state and, when appropriate, relevant adult input through
1567 screenings, interviews and questions.

1568 “Primary care provider”, a health care professional qualified to provide general medical
1569 care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise
1570 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
1571 maintains continuity of care within the scope of practice.

1572 (b) The following shall provide coverage for an annual mental health wellness
1573 examination that is performed by a licensed mental health professional or primary care provider,
1574 which may be provided by the primary care provider as part of an annual preventive visit: (i) any
1575 policy of accident and sickness insurance, as described in section 108, which provides hospital

1576 expense and surgical expense insurance and which is delivered, issued or subsequently renewed
1577 by agreement between the insurer and policyholder in the commonwealth; (ii) any blanket or
1578 general policy of insurance described in subdivision (A), (C) or (D) of section 110 which
1579 provides hospital expense and surgical expense insurance and which is delivered, issued or
1580 subsequently renewed by agreement between the insurer and the policyholder in or outside of the
1581 commonwealth; and (iii) any employees' health and welfare fund which provides hospital
1582 expense and surgical expense benefits and which is delivered, issued to or renewed for any
1583 person or group of persons in the commonwealth. The examination shall be covered with no
1584 patient cost-sharing.

1585 (c) The division of insurance, in consultation with the office of Medicaid, and the
1586 department of mental health, shall develop guidelines to implement this section.

1587 SECTION 43. Section 8A of chapter 176A of the General Laws, as appearing in the 2020
1588 Official Edition, is hereby amended by inserting after the word "specialist", in line 125, the
1589 following words:- , a clinician practicing under the supervision of a licensed professional and
1590 working towards licensure in a clinic licensed under chapter 111.

1591 SECTION 44. Said chapter 176A is hereby further amended by inserting after section
1592 8QQ the following 4 sections:-

1593 Section 8RR. For the purposes of this section, "psychiatric collaborative care model"
1594 shall mean the evidence-based, integrated behavioral health service delivery method described in
1595 81 FR 80230.

1596 A contract between a subscriber and the corporation under an individual or group hospital
1597 service plan that is delivered, issued or renewed within or without the commonwealth shall

1598 provide coverage for mental health or substance use disorder services that are delivered through
1599 the psychiatric collaborative care model.

1600 Section 8SS. (a) For the purposes of this section, the following terms shall have the
1601 following meanings unless the context clearly requires otherwise:

1602 “Community-based acute treatment”, 24-hour clinically managed mental health
1603 diversionary or step-down services for children and adolescents that is usually provided as an
1604 alternative to mental health acute treatment.

1605 “Intensive community-based acute treatment”, intensive 24-hour clinically managed
1606 mental health diversionary or step-down services for children and adolescents that is usually
1607 provided as an alternative to mental health acute treatment.

1608 “Mental health acute treatment”, 24-hour medically supervised mental health services
1609 provided in an inpatient facility, licensed by the department of mental health, that provides
1610 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
1611 milieu.

1612 (b) A contract between a subscriber and the corporation under an individual or group
1613 hospital service plan that is delivered, issued or renewed within the commonwealth shall provide
1614 coverage for medically necessary mental health acute treatment, community-based acute
1615 treatment and intensive community-based acute treatment and shall not require a
1616 preauthorization before the administration of any such treatment; provided, however, that the
1617 facility shall notify the carrier of the admission and the initial treatment plan within 72 hours of
1618 admission.

1619 Section 8TT. A contract between a subscriber and the corporation under an individual or
1620 group hospital service plan that is delivered, issued or renewed within or without the
1621 commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary
1622 emergency services programs, as defined in section 1 of chapter 175.

1623 Section 8UU. (a) For the purpose of this section, the following words shall have the
1624 following meanings:

1625 “Licensed mental health professional,” a licensed physician who specializes in the
1626 practice of psychiatry, a licensed psychologist, a licensed supervised mental health counselor, a
1627 licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse
1628 mental health clinical specialist, a licensed physician assistant who practices in the area of
1629 psychiatry, a licensed alcohol and drug counselor I, as defined in section 1 of chapter 111J of the
1630 General Laws, or a licensed marriage and family therapist within the lawful scope of practice for
1631 such therapist.

1632 “Mental health wellness examination,” a screening or assessment that seeks to identify
1633 any behavioral or mental health needs and appropriate resources for treatment. The examination
1634 may include: (i) observation, a behavioral health screening, education and consultation on
1635 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
1636 necessary supports and discussion of potential options for medication; and (ii) age-appropriate
1637 screenings or observations to understand a covered person’s mental health history, personal
1638 history and mental or cognitive state and, when appropriate, relevant adult input through
1639 screenings, interviews, and questions.

1640 “Primary care provider”, a health care professional qualified to provide general medical
1641 care for common health care problems, who (i) supervises, coordinates, prescribes or otherwise
1642 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
1643 maintains continuity of care within the scope of practice.

1644 (b) A contract between a subscriber and the corporation under an individual or group
1645 hospital service plan which is delivered, issued or renewed within the commonwealth shall
1646 provide coverage for an annual mental health wellness examination that is performed by a
1647 licensed mental health professional or primary care provider, which may be provided by the
1648 primary care provider as part of an annual preventive visit. The examination shall be covered
1649 with no patient cost-sharing.

1650 (c) The division of insurance, in consultation with the office of Medicaid, and the
1651 department of mental health, shall develop guidelines to implement this section.

1652 SECTION 45. Section 4A of chapter 176B of the General Laws, as appearing in the 2020
1653 Official Edition, is hereby amended by inserting after the word “specialist”, in line 120, the
1654 following words:- , a clinician practicing under the supervision of a licensed professional and
1655 working towards licensure in a clinic licensed under chapter 111.

1656 SECTION 46. Said chapter 176B is hereby further amended by inserting after section
1657 4QQ the following 4 sections:-

1658 Section 4RR. (a) For the purposes of this section, “psychiatric collaborative care model”
1659 shall mean the evidence-based, integrated behavioral health service delivery method described in
1660 81 FR 80230.

1661 A subscription certificate under an individual or group medical service agreement that is
1662 issued or renewed within or without the commonwealth shall provide coverage for mental health
1663 or substance use disorder services that are delivered through the psychiatric collaborative care
1664 model.

1665 Section 4SS. For the purposes of this section, the following terms shall have the
1666 following meanings unless the context clearly requires otherwise:

1667 “Community-based acute treatment”, 24-hour clinically managed mental health
1668 diversionary or step-down services for children and adolescents that is usually provided as an
1669 alternative to mental health acute treatment.

1670 “Intensive community-based acute treatment”, intensive 24-hour clinically managed
1671 mental health diversionary or step-down services for children and adolescents that is usually
1672 provided as an alternative to mental health acute treatment.

1673 “Mental health acute treatment”, 24-hour medically supervised mental health services
1674 provided in an inpatient facility, licensed by the department of mental health, that provides
1675 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
1676 milieu.

1677 (b) A subscription certificate under an individual or group medical service agreement
1678 delivered, issued or renewed within the commonwealth shall provide coverage for medically
1679 necessary mental health acute treatment, community-based acute treatment, intensive
1680 community-based acute treatment and shall not require a preauthorization before obtaining
1681 treatment; provided, however, that the facility shall notify the carrier of the admission and the
1682 initial treatment plan within 72 hours of admission.

1683 Section 4TT. A subscription certificate under an individual or group medical service
1684 agreement that is issued or renewed shall provide benefits on a nondiscriminatory basis for
1685 medically necessary emergency services programs, as defined in section 1 of chapter 175.

1686 Section 4UU. (a) For the purpose of this section, the following words shall have the
1687 following meanings:

1688 “Licensed mental health professional,” a licensed physician who specializes in the
1689 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a
1690 licensed mental health counselor, a licensed supervised mental health counselor, a licensed nurse
1691 mental health clinical specialist, a licensed physician assistant who practices in the area of
1692 psychiatry, a licensed alcohol and drug counselor I, as defined in section 1 of chapter 111J, or a
1693 licensed marriage and family therapist within the lawful scope of practice for such therapist.

1694 “Mental health wellness examination,” a screening or assessment that seeks to identify
1695 any behavioral or mental health needs and appropriate resources for treatment. The examination
1696 may include: (i) observation, a behavioral health screening, education and consultation on
1697 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
1698 necessary supports, and discussion of potential options for medication; and (ii) age-appropriate
1699 screenings or observations to understand a covered person’s mental health history, personal
1700 history and mental or cognitive state and, when appropriate, relevant adult input through
1701 screenings, interviews, and questions.

1702 “Primary care provider”, a health care professional qualified to provide general medical
1703 care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise

1704 provides or proposes health care services; (ii) initiates referrals for specialist care; (iii) and
1705 maintains continuity of care within the scope of practice.

1706 (b) A subscription certificate under an individual or group medical service agreement
1707 delivered, issued or renewed within the commonwealth shall provide coverage for an annual
1708 mental health wellness examination that is performed by a licensed mental health professional or
1709 primary care provider, which may be provided by the primary care provider as part of an annual
1710 preventive visit. The examination shall be covered with no patient cost-sharing.

1711 (c) The division of insurance, in consultation with the office of Medicaid, and the
1712 department of mental health, shall develop guidelines to implement this section.

1713 SECTION 47. Section 4M of chapter 176G of the General Laws, as appearing in the
1714 2020 Official Edition, is hereby amended by inserting after the word “specialist”, in line 117, the
1715 following words:- , a clinician practicing under the supervision of a licensed professional and
1716 working towards licensure in a clinic licensed under chapter 111.

1717 SECTION 48. Said chapter 176G is hereby further amended by inserting after section 4II
1718 the following 4 sections:-

1719 Section 4JJ. For the purposes of this section, “psychiatric collaborative care model” shall
1720 mean the evidence-based, integrated behavioral health service delivery method described in 81
1721 FR 80230.

1722 Any individual or group health maintenance contract that is issued or renewed within or
1723 without the commonwealth shall provide coverage for mental health or substance use disorder
1724 services that are delivered through the psychiatric collaborative care model.

1725 Section 4KK. (a) For the purposes of this section, the following terms shall have the
1726 following meanings unless the context clearly requires otherwise:

1727 “Community-based acute treatment”, 24-hour clinically managed mental health
1728 diversionary or step-down services for children and adolescents that is usually provided as an
1729 alternative to mental health acute treatment.

1730 “Intensive community-based acute treatment”, intensive 24-hour clinically managed
1731 mental health diversionary or step-down services for children and adolescents that is usually
1732 provided as an alternative to mental health acute treatment.

1733 “Mental health acute treatment”, 24-hour medically supervised mental health services
1734 provided in an inpatient facility, licensed by the department of mental health, that provides
1735 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
1736 milieu.

1737 (b) An individual or group health maintenance contract that is issued or renewed within
1738 or without the commonwealth shall provide coverage for medically necessary mental health
1739 acute treatment, community-based acute treatment and intensive community-based acute
1740 treatment and shall not require a preauthorization before the administration of such treatment;
1741 provided, however, that the facility shall notify the carrier of the admission and the initial
1742 treatment plan within 72 hours of admission.

1743 Section 4LL. An individual or group health maintenance contract that is issued or
1744 renewed within or without the commonwealth shall provide benefits on a nondiscriminatory
1745 basis for medically necessary emergency services programs, as defined in section 1 of chapter
1746 175.

1747 Section 4MM. (a) For the purpose of this section, the following words shall have the
1748 following meanings unless the context clearly requires otherwise:

1749 “Licensed mental health professional,” a licensed physician who specializes in the
1750 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a
1751 licensed mental health counselor, a licensed supervised mental health counselor, a licensed nurse
1752 mental health clinical specialist a licensed physician assistant who practices in the area of
1753 psychiatry, a licensed alcohol and drug counselor I, as defined in section 1 of chapter 111J, or a
1754 licensed marriage and family therapist within the lawful scope of practice for such therapist.

1755 “Mental health wellness examination,” a screening or assessment that seeks to identify
1756 any behavioral or mental health needs and appropriate resources for treatment. The examination
1757 may include: (i) observation, a behavioral health screening, education and consultation on
1758 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
1759 necessary supports, and discussion of potential options for medication; and (ii) age-appropriate
1760 screenings or observations to understand a covered person’s mental health history, personal
1761 history and mental or cognitive state and, when appropriate, relevant adult input through
1762 screenings, interviews and questions.

1763 “Primary care provider”, a health care professional qualified to provide general medical
1764 care for common health care problems, who (i) supervises, coordinates, prescribes or otherwise
1765 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
1766 maintains continuity of care within the scope of practice.

1767 (b) An individual or group health maintenance contract that is issued or renewed within
1768 or without the commonwealth shall provide coverage for an annual mental health wellness

1769 examination that is performed by a licensed mental health professional or primary care provider,
1770 which may be provided by the primary care provider as part of an annual preventive visit. The
1771 examination shall be covered with no patient cost-sharing.

1772 (c) The division of insurance, in consultation with the office of Medicaid, and the
1773 department of mental health, shall develop guidelines to implement this section.

1774 SECTION 49. Chapter 176O of the General Laws is hereby amended by inserting after
1775 section 5C the following section:-

1776 Section 5D. For the purposes of this section, the term “base fee schedule” shall mean the
1777 minimum rates, typically set forth in fee schedules, paid by the carrier to an in-network health
1778 care provider who is not paid under an alternative payment arrangement for covered health care
1779 services; provided, however, that final rates may be subject to negotiations or adjustments that
1780 may result in payments to in-network providers that are different from the base fee schedule.

1781 A carrier, directly or through any entity that manages or administers mental health or
1782 substance use disorder benefits for the carrier, shall establish a base fee schedule for evaluation
1783 and management services for behavioral health providers that is not less than the base fee
1784 schedule used for evaluation and management services for primary care providers of the same or
1785 similar licensure type and in the same geographic region; provided, however, that a carrier shall
1786 not lower its base fee schedule for primary care providers to comply with this section.

1787 The division shall promulgate regulations to implement this section.

1788 SECTION 50. Subsection (a) of section 13 of said chapter 176O, as appearing in the
1789 2020 Official Edition, is hereby amended by striking out the first sentence and inserting in place
1790 thereof the following sentence:-

1791 A carrier or utilization review organization shall maintain a formal internal grievance
1792 process that is compliant with the Patient Protection and Affordable Care Act, Public Law 111-
1793 148, as amended, as well as with any rules, regulations or guidance applicable thereto, and such
1794 formal internal grievance process shall provide for adequate consideration and timely resolution
1795 of grievances, which shall include but not be limited to: (i) a system for maintaining records of
1796 each grievance filed by an insured or on the insured's behalf, and responses thereto, for a period
1797 of 7 years, which records shall be subject to inspection by the commissioner; (ii) the provision of
1798 a clear, concise and complete description of the carrier's formal internal grievance process and
1799 the procedures for obtaining external review pursuant to section 14 with each notice of an
1800 adverse determination; (iii) the carrier's toll-free telephone number for assisting insureds in
1801 resolving such grievances and the consumer assistance toll-free telephone number maintained by
1802 the office of patient protection; (iv) a written acknowledgement of the receipt of a grievance
1803 within 15 days and a written resolution of each grievance sent to the insured by certified or
1804 registered mail, or other express carrier with proof of delivery, within 30 days from receipt
1805 thereof; (v) a procedure to accept grievances by telephone, in person, by mail and by electronic
1806 means; (vi) a process for an insured to request the appointment of an authorized representative to
1807 act on the insured's behalf; and (vii) a procedure to accept an insured's request for medical
1808 release forms by electronic means, which shall include delivery to a designated email address or
1809 access to an online consumer portal accessible by the insured, the insured's family member or

1810 the insured's authorized representative who can provide the insured's membership identification
1811 number.

1812 SECTION 51. Subsection (b) of said section 13 of said chapter 176O, as so appearing, is
1813 hereby amended by striking out the third sentence and inserting in place thereof the following
1814 sentence:- If the expedited review process affirms the denial of coverage or treatment, the carrier
1815 shall provide the insured, within 2 business days of the decision, including by any electronic
1816 means consented to by the insured: (1) a statement setting forth the specific medical and
1817 scientific reasons for denying coverage or treatment; (2) a description of alternative treatment,
1818 services or supplies covered or provided by the carrier, if any; (3) a description of the insured's
1819 rights to any further appeal; and (4) a description of the insured's right to request a conference.

1820 SECTION 52. Subsection (c) of said section 13 of said chapter 176O, as so appearing, is
1821 hereby amended by adding the following sentence:- The external review of a grievance under
1822 section 14 shall be decided in favor of the insured unless the carrier provides substantial
1823 evidence, such as proof of delivery, that the carrier properly complied with the time limits
1824 required under this section.

1825 SECTION 53. Subsection (a) of section 14 of said chapter 176O, as so appearing, is
1826 hereby amended by striking out the eighth sentence and inserting in place thereof the following
1827 sentence:- The panel shall consider, but not be limited to considering: (i) any related right to such
1828 treatment or service under any related state statute or regulation; (ii) written documents
1829 submitted by the insured; (iii) medical records and medical opinions regarding medical necessity
1830 by the insured's treating provider that requested or provided the disputed service, which shall be
1831 obtained by the carrier, or by the panel if the carrier fails to do so; (iv) additional information

1832 from the involved parties or outside sources that the review panel deems necessary or relevant;
1833 and (v) information obtained from any informal meeting held by the panel with the parties.

1834 SECTION 54. Subsection (b) of said section 14 of said chapter 176O, as so appearing, is
1835 hereby amended by striking out the second sentence and inserting in place thereof the following
1836 sentence:- An insured may apply to the external review panel to seek continued provision of
1837 health care services that are the subject of the grievance during the course of an expedited or
1838 non-expedited external review upon a showing of substantial harm to the insured's health absent
1839 such continuation or other good cause as determined by the panel; provided, however, that good
1840 cause shall include a pattern of denials that have been overturned by prior internal or external
1841 appeals.

1842 SECTION 55. Subsection (c) of said section 14 of said chapter 176O, as so appearing, is
1843 hereby amended by adding the following sentence:- A carrier's failure to promptly comply with
1844 a decision of the review panel shall be an unfair and deceptive practice in violation of chapter
1845 93A.

1846 SECTION 56. Said section 14 of said chapter 176O, as so appearing, is hereby further
1847 amended by adding following subsection:-

1848 (g) The office of patient protection shall monitor carrier denials and shall identify any
1849 trends regarding particular treatments or services or carrier practices and may refer such matters
1850 to the division of insurance, the group insurance commission or the office of the attorney general
1851 for review for compliance with state or federal laws related to mental health and substance use
1852 disorder parity including, but not limited to, section 22 of chapter 32A, section 47B of chapter
1853 175, section 8A of chapter 176A, section 4A of chapter 176B and sections 4, 4B and 4M of

1854 chapter 176G, in regard to any carrier licensed under chapters 175, 176A, 176B or 176G, any
1855 carrier offering a student health plan issued under section 18 of chapter 15A or the group
1856 insurance commission, or the mental health parity provisions of the federal Paul Wellstone and
1857 Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), as
1858 amended, and federal guidance or regulations issued under the act. The office of patient
1859 protection shall refer any questions or concerns from consumers about carrier compliance with
1860 state or federal laws related to mental health and substance use disorder parity to the division of
1861 insurance, the group insurance commission or the office of the attorney general.

1862 SECTION 57. Subsection (b) of section 16 of said chapter 176O, as so appearing, is
1863 hereby amended by striking out the last sentence and inserting in place thereof the following
1864 sentence:- If a carrier or utilization review organization intends to implement a new medical
1865 necessity guideline or amend an existing requirement or restriction, the carrier or utilization
1866 review organization shall ensure that the new guideline or amended requirement or restriction
1867 shall not be implemented unless: (i) the carrier's or utilization review organization's website has
1868 been updated to reflect the new or amended requirement or restriction; and (ii) the carrier or
1869 utilization review organization has assessed the limitation to show it is in compliance with state
1870 and federal parity requirements under chapter 26.

1871 SECTION 58. Said section 16 of said chapter 176O, as so appearing, is hereby further
1872 amended by adding the following subsection:-

1873 (d) Medical necessity and utilization management determinations for treatments for
1874 substance use disorder or co-occurring mental illness and substance use disorder shall be made in
1875 accordance with the criteria established by the American Society of Addiction Medicine. No

1876 additional criteria may be used to make medical necessity or utilization management
1877 determinations for treatments for substance use disorder or co-occurring mental illness and
1878 substance use disorder, unless such criteria are less restrictive. A carrier, or any entity that
1879 manages or administers mental health and substance use disorder benefits for the carrier, shall
1880 not deny authorization or coverage for treatment for substance use disorder or co-occurring
1881 mental illness and substance use disorder on the basis that such treatment was authorized or
1882 ordered by a court of law or other law enforcement agency. Such authorization shall be
1883 considered a factor in support of coverage for such treatment, including as allowed under clause
1884 (4) of subsection (a) of section 6 and clause (7) of subsection (a) of section 7.

1885 SECTION 59. The interagency health equity team, as supported through the office of
1886 health equity, shall, in consultation with the advisory council appointed in this section, study
1887 ways to improve access to, and the quality of, culturally competent behavioral health services.
1888 The review shall include, but not be limited to: (i) the need for greater racial, ethnic and
1889 linguistic diversity within the behavioral health workforce; (ii) the role of gender, sexual
1890 orientation, gender identity, race, ethnicity, linguistic barriers, status as a client of the department
1891 of children and families, status as an incarcerated or formerly incarcerated individual, including
1892 justice-involved youth and emerging adults, status as a veteran, status as an individual with post-
1893 traumatic stress disorder, status as an aging adult, status as a person with any other physical or
1894 invisible disability and social determinants of health regarding behavioral health needs; and (iii)
1895 any other factors identified by the team that create disparities in access and quality within the
1896 existing behavioral health service delivery system, including stigma, transportation and cost.

1897 The advisory council shall consist of: the chairs of the joint committee on mental health,
1898 substance use and recovery; the chair of the Black and Latino Caucus or a designee; and 8

1899 members to be appointed by the commissioner of public health, 1 of whom shall be a local public
1900 health official representing a majority-minority municipality, 1 of whom shall be a representative
1901 of a racial or ethnic equity advocacy group, 1 of whom shall be a representative of a linguistic
1902 equity advocacy group, 1 of whom shall be a licensed behavioral health provider, 1 of whom
1903 shall be a representative of a behavioral health advocacy group, 1 of whom shall be a
1904 representative of an organization serving the health care needs of the lesbian, gay, bisexual,
1905 transgender, queer and questioning community, 1 of whom shall be a representative of an
1906 organization serving the health care needs of individuals experiencing housing insecurity and 1
1907 of whom shall be an individual with expertise in school-based behavioral health services.

1908 The team shall meet not less than quarterly with the advisory council. Not later than
1909 March 30, 2022, and annually for the following 3 years at the close of the fiscal year, the team
1910 shall issue a report with legislative, regulatory or budgetary recommendations to improve the
1911 access and quality of culturally competent mental and behavioral health services. The report shall
1912 be written in non-technical, readily understandable language and shall be made publicly
1913 available on the office of health equity’s website.

1914 The office of health equity, the department of mental health and the department of public
1915 health may, subject to appropriation, provide administrative, logistical and research support to
1916 produce the report.

1917 SECTION 60. The health policy commission, in consultation with the division of
1918 insurance, shall conduct an analysis of the effects of behavioral health managers, as defined in
1919 section 1 of chapter 176O of the General Laws, on the commonwealth’s health care delivery
1920 system. The commission shall seek input from the executive office of health and human services,

1921 other state agencies, health care providers and payers, behavioral health and economic experts,
1922 patients and caregivers.

1923 The commission shall analyze: (i) the services that behavioral health managers provide;
1924 (ii) the effect of behavioral health managers on accessibility, quality and cost of behavioral
1925 health services, including an analysis of their impact on patient outcomes; (iii) the oversight
1926 practices by other states on behavioral health managers; (iv) the effects of behavioral health
1927 manager state licensure, regulation or registration on access to behavioral health services; and (v)
1928 any other issues pertaining to behavioral health managers as deemed relevant by the commission.

1929 Not later than December 31, 2022, the health policy commission shall file a report of its
1930 findings, together with any recommendations for legislation, with the clerks of the senate and
1931 house of representatives, the joint committee on health care financing, the joint committee on
1932 mental health, substance use and recovery and the joint committee on financial services.

1933 SECTION 61. There shall be a special commission to study and make recommendations
1934 on the establishment of a common set of criteria for providers and payers to use in making
1935 medical necessity determinations for behavioral health treatment.

1936 The commission shall consist of the following members or their designees: the
1937 commissioner of mental health, who shall serve as chair; the commissioner of insurance; the
1938 director of the bureau of substance addiction services within the department of public health; the
1939 assistant secretary for MassHealth; the executive director of the group insurance commission;
1940 and 17 members to be appointed by the chair: 1 of whom shall be a representative of the health
1941 policy commission; 2 of whom shall be representatives of the Massachusetts Psychiatric Society,
1942 Inc., 1 of whom shall specialize in the treatment of children; 2 of whom shall be representatives

1943 of the Massachusetts Psychological Association, Inc., 1 of whom shall specialize in the treatment
1944 of children; 1 of whom shall be a representative of the Massachusetts Society of Addiction
1945 Medicine, Inc.; 1 of whom shall be a representative of the National Association of Social
1946 Workers, Inc.; 1 of whom shall be a representative of the Massachusetts Mental Health
1947 Counselors Association, Inc.; 1 of whom shall be a representative of the Children’s Mental
1948 Health Campaign; 1 of whom shall be a representative of the Association for Behavioral
1949 Healthcare, Inc.; 1 of whom shall be a representative of the Massachusetts Association of
1950 Behavioral Health Systems, Inc.; 1 of whom shall be a representative of the Massachusetts
1951 Health and Hospital Association;; 1 of whom shall be a representative of the Massachusetts
1952 Association for Mental Health, Inc.; 1 of whom shall be a representative of the National Alliance
1953 on Mental Illness of Massachusetts, Inc.; 1 of whom shall be a representative of the
1954 Massachusetts Organization for Addiction Recovery, Inc.; 1 of whom shall be a representative of
1955 Blue Cross and Blue Shield of Massachusetts, Inc.; and 1 of whom shall be a representative of
1956 the Massachusetts Association of Health Plans, Inc..

1957 The commission’s review shall include, but not be limited to: (i) existing reference
1958 sources or services utilized by payers to make medical necessity determinations for behavioral
1959 health treatment; (ii) commonly accepted treatment guidelines and standards of care utilized by
1960 behavioral health providers and the evidentiary basis for those guidelines and standards; (iii) the
1961 feasibility of establishing a common set of medical necessity criteria that behavioral health
1962 providers and payers can agree to and any barriers to this task; and (iv) the experiences of other
1963 states in addressing the standardization of medical necessity for behavioral health.

1964 Not later than 1 year after the effective date of this act, the commission shall submit its
1965 findings and recommendations, together with drafts of legislation or regulations necessary to

1966 carry those recommendations into effect, to the clerks of the senate and house of representatives
1967 and the joint committee on mental health, substance use and recovery.

1968 SECTION 62. The health policy commission shall convene an advisory group to advise
1969 the commission on the implementation of section 21 of chapter 6D of the General Laws. The
1970 advisory group shall include: the director of the health policy commission or a designee, who
1971 shall serve as chair; the secretary of health and human services or a designee; the assistant
1972 secretary of MassHealth or a designee; the commissioner of insurance or a designee; 1 member
1973 appointed by the governor, who shall be from a commonwealth-based electronic health record
1974 vendor who specializes in behavioral health care; 1 member appointed by the Association for
1975 Behavioral Healthcare, Inc.; 1 member appointed by Blue Cross and Blue Shield of
1976 Massachusetts, Inc.; 1 member appointed by Health Law Advocates, Inc.; 1 member appointed
1977 by the Massachusetts Association of Health Plans, Inc.; 1 member appointed by the
1978 Massachusetts Health and Hospital Association, Inc.; 1 member appointed by National Alliance
1979 on Mental Illness of Massachusetts, Inc.; 1 member appointed by the Massachusetts
1980 Organization for Addiction Recovery, Inc. ; 1 of who shall be a person who has received mental
1981 health or substance use disorder treatment; 1 of whom shall be a family member of a person
1982 being treated for a mental health or substance use disorder substance use disorder; and 1 member
1983 appointed by the Parent/Professional Advocacy League, Inc.

1984 The advisory group shall study and make recommendations on the development and
1985 proper use of the standard release form required under said section 21 of said chapter 6D. The
1986 advisory group shall consider: (i) existing and potential technologies that could be used to
1987 securely transmit a standard release form; (ii) national standards pertaining to electronic release
1988 of confidential information, including protecting a patient's identity and privacy in accordance

1989 with the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191; (iii)
1990 any prior release forms and methodologies used in the commonwealth; (iv) any prior release
1991 forms and methodologies developed by federal agencies; and (v) any other factors the advisory
1992 group deems relevant.

1993 The advisory group shall submit written recommendations to the commission not more
1994 than 6 months after the effective date of this act. The commission shall develop the standard
1995 release form after receiving the advisory group's recommendations.

1996 SECTION 63. There shall be a special commission to review and make recommendations
1997 on reducing, streamlining or eliminating barriers to accessing mental health care services without
1998 decreasing care quality, patient safety or program integrity in the commonwealth.

1999 The commission shall consist of the following members or their designees: the secretary
2000 of health and human services, who shall serve as chair; the commissioner of insurance; the
2001 assistant secretary for MassHealth; the commissioner of public health; the director of health
2002 professions licensure; the commissioner of mental health; the chair of the board of registration in
2003 medicine; a representative of the Massachusetts Association for Mental Health, Inc.; a
2004 representative of the Children's Mental Health Campaign; a representative of the National
2005 Alliance on Mental Illness of Massachusetts, Inc.; a representative of the Association for
2006 Behavioral Healthcare, Inc; a representative of the Massachusetts League of Community Health
2007 Centers, Inc.; a representative of the Massachusetts Health and Hospital Association, Inc.; a
2008 representative of Blue Cross and Blue Shield of Massachusetts, Inc.; a representative of the
2009 Massachusetts Association of Health Plans, Inc.; a representative of the Massachusetts
2010 Psychiatric Society, Inc.; a representative of the Massachusetts Psychological Association, Inc.; a

2011 representative of the National Association of Social Workers, Inc.; a representative of the
2012 Massachusetts Association of Advanced Practice Psychiatric Nurses, Inc.; a representative of the
2013 Massachusetts Mental Health Counselors Association, Inc.; and a representative of the
2014 Massachusetts Medical Society.

2015 The commission shall review the barriers to accessing mental health care services
2016 including, but not limited to: (i) administrative tasks that may divert mental health providers’
2017 time and attention from patient care, including credentialing, billing and reimbursement
2018 processes; (ii) the impact of public and private insurance carriers’ utilization management
2019 policies including, but not limited to, prior authorization, utilization review, medical necessity
2020 standards and clinical guidelines on patient care delivery; (iii) the payment rates, payment
2021 structures and methods of payment for mental health care services; and (iv) the reasons that
2022 mental health providers do not accept public or private insurance and the ways to incentivize the
2023 acceptance of such insurance.

2024 The commission shall report its findings and submit recommendations to the clerks of the
2025 senate and house of representatives, the joint committee on mental health, substance use and
2026 recovery and the joint committee on health care financing not later than 1 year from the effective
2027 date of this act. The executive office shall make the report publicly available on its website.

2028 SECTION 64. (a) The department of veterans’ services shall convene an advisory
2029 committee that shall consist of: 2 representatives of the Massachusetts chapter of Team Red,
2030 White & Blue; 2 representatives of the Red Sox Foundation and Massachusetts General
2031 Hospital’s Home Base Program; 2 representatives of the Wounded Warriors Project; 2
2032 representatives of the Mass Mentoring Partnership, Inc.; 2 representatives of the Massachusetts

2033 Coalition for Suicide Prevention; 2 representatives of the Massachusetts Psychological
2034 Association, Inc.; and such other members as the committee deems necessary. The members of
2035 the committee shall have experience in mental health or veterans' support services with an
2036 emphasis on treatment of post-traumatic stress disorder, depression and anxiety among veterans.

2037 (b) The committee, in coordination with the department of veterans' services and the
2038 department of mental health, shall investigate and study: (i) ways to augment services to
2039 returning veterans to reduce the rate of suicide and the effects of post-traumatic stress disorder,
2040 depression and anxiety; and (ii) the complexity of reintegration into civilian life and issues
2041 related to isolation and suicide among veterans. The committee shall provide support and
2042 expertise to reduce isolation and suicide among returning veterans.

2043 The committee shall examine: (i) the impact of having a community peer liaison on a
2044 veteran's reintegration into society; (ii) the relationship between isolation and suicide among
2045 veterans; and (iii) the impact of having a community peer liaison on symptoms of post-traumatic
2046 stress disorder, depression and anxiety in diagnosed veterans.

2047 The committee shall file a report of its findings and any recommendations, with the
2048 clerks of the senate and house of representatives, the joint committee on veterans and federal
2049 affairs and the joint committee on mental health, substance use and recovery not later than
2050 January 1, 2023.

2051 SECTION 65. The executive office of public safety and security, in consultation with the
2052 department of mental health, the department of public health and the department of veterans'
2053 services, shall examine: (i) the extent to which municipal and state police, firefighters, public
2054 safety personnel and veterans participate in behavioral health screening and treatment, if known;

2055 (ii) barriers to municipal and state police, firefighters, public safety personnel and veterans
2056 participation in behavioral health screening and treatment; and (iii) current programs and best
2057 practices to incentivize and support municipal and state police, firefighters, public safety
2058 personnel and veterans to participate in behavioral health screening and treatment.

2059 Not later than 90 days after the effective date of this act, the executive office of public
2060 safety and security shall submit its findings and any recommendations for improving access to
2061 and participation in behavioral health screening and treatment by municipal and state police,
2062 firefighters, public safety personnel and veterans to the clerks of the senate and the house of
2063 representatives, the joint committee on public safety and homeland security and the joint
2064 committee on mental health, substance use and recovery.

2065 SECTION 66. The department of mental health shall prepare a comprehensive plan to
2066 address access to continuing care beds, intensive residential treatment programs and community-
2067 based programs for patients awaiting discharge from acute psychiatric hospitals and units. The
2068 plan shall include, but not be limited to, strategies to reduce the wait times for patients awaiting
2069 discharge so that the patients determined appropriate for continuing care, intensive residential
2070 treatment and community-based programs would be admitted to an appropriate continuing care
2071 bed, intensive residential treatment program, community-based program or other appropriate
2072 setting within 30 days after approval of their application. The department of mental health shall
2073 submit a copy of the plan to the governor, the clerks of the senate and house of representatives
2074 and the joint committee on mental health, substance use and recovery within 60 days after the
2075 effective date of this act.

2076 SECTION 67. (a) There shall be within the department of public health's division of
2077 violence and injury prevention a suicide postvention task force to address the aftereffects of a
2078 confirmed suicide. Using recent data, the task force shall prepare best practices and mental health
2079 standards and a postvention care kit that shall include materials and contact information for grief
2080 counseling that shall be made available to suicide loss survivors in the aftermath of a suicide.
2081 The task force shall study best practices and privacy considerations in proactively distributing
2082 the care kit or other resources to family members and loss survivors at risk of suicide behavior
2083 contagion.

2084 (b) The suicide postvention task force shall consist of the following members or their
2085 designees: the director of the Massachusetts Suicide Prevention Program, who shall serve as
2086 chair; the secretary of health and human services; and 6 persons to be appointed by the chair, 1
2087 of whom shall be a representative of the National Alliance on Mental Illness of Massachusetts,
2088 Inc., 1 of whom shall be a representative of the Parent/Professional Advocacy League, Inc., 1 of
2089 whom shall be a representative of the Massachusetts Coalition for Suicide Prevention, 1 of whom
2090 shall be a representative of Riverside Community Care, Inc., 1 of whom shall be a representative
2091 of the Samaritans, Inc. and 1 of whom shall be an individual who has experienced a suicide
2092 within their family.

2093 (c) The task force shall prepare its findings and recommendations, together with drafts of
2094 legislation or regulations necessary to carry those recommendations into effect, by filing the
2095 same with the clerks of the senate and house of representatives and the joint committee on
2096 mental health, substance use and recovery not later than 1 year after the effective date of this act.

2097 SECTION 68. For the purposes of this section, the term “dual diagnosis” shall mean a
2098 mental illness and a substance abuse problem occurring simultaneously in the same individual.

2099 The department of mental health shall establish a behavioral health emergency
2100 department relief pilot program, with not less than 15 beds, on the campus of Taunton state
2101 hospital; provided, however, that the 15 pilot program beds shall be supplementary to the
2102 existing long-term care beds operated by the department and the existing men’s and women’s
2103 recovery from addictions program beds located on the Taunton state hospital campus, to accept
2104 medically stable, high acuity behavioral health and dual diagnosis patients from emergency
2105 departments in the southeast region of the commonwealth. Medically stable patients presenting
2106 in an emergency department with a high acuity behavioral health condition or a dual diagnosis
2107 shall be transferred to the pilot program if another appropriate setting cannot be located within 4
2108 hours of admission to the emergency department. A patient who is admitted to the pilot program
2109 shall be cared for until an appropriate placement is found that meets the patient’s needs;
2110 provided, however, that the pilot program shall care for patients either for 14 days following
2111 admission or until an appropriate placement is found that meets the patient's needs, whichever is
2112 sooner. The program shall be operated and staffed by the department of mental health as needed
2113 to provide appropriate care. The department of mental health, in consultation with the
2114 department of public health, the National Alliance on Mental Illness of Massachusetts, Inc., the
2115 Massachusetts Nurses Association and the Emergency Nurses Association, shall develop
2116 program protocols and a staffing plan for the pilot program not later than 6 months after the
2117 effective date of this act. The pilot program shall operate for not more than 2 years.

2118 The department of mental health shall file a report with the joint committee on mental
2119 health, substance use and recovery during the final year of the program to evaluate: (i) the impact

2120 of the program on emergency department overcrowding in the southeast region of the
2121 commonwealth; and (ii) the quality of care provided in the program. The report may be drafted
2122 by an independent entity, utilizing data from the department of mental health and local hospitals
2123 in the southeast region of the commonwealth.

2124 SECTION 69. The state 911 department shall update 560 CMR 5.00 to integrate training
2125 on identification of and response to callers experiencing behavioral health crises, which may
2126 include crisis intervention training and training on the appropriate diversion of people with
2127 behavioral health conditions away from law enforcement response to appropriate behavioral
2128 health treatment and support, into the certification standards for certified enhanced 911
2129 telecommunicators.

2130 SECTION 70. The division of insurance shall promulgate regulations to implement
2131 section 5D of chapter 176O of the General Laws not later than 1 year from the effective date of
2132 this act; provided, however, that the division shall, upon publication, forward any draft
2133 regulations to the joint committee on health care financing and the joint committee on mental
2134 health, substance use and recovery.

2135 SECTION 71. The health policy commission shall publish its first pediatric behavioral
2136 health planning report required by section 20 of chapter 6D of the General Laws not later than 18
2137 months after the effective date of this act.

2138 SECTION 72. For the purposes of section 22A of chapter 32A of the General Laws,
2139 section 10P of chapter 118E of the General Laws, section 47MM of chapter 175 of the General
2140 Laws, section 8OO of chapter 176A of the General Laws, section 4OO of chapter 176B of the
2141 General Laws and section 4GG of chapter 176G of the General Laws, reimbursement for the

2142 psychiatric collaborative care model shall include, but not be limited to, the following current
2143 procedural terminology billing codes established by the American Medical Association: (i)
2144 99492; (ii) 99493; and (iii) 99494.

2145 SECTION 73. The office of the child advocate shall publish the first annual report
2146 required by section 10A of chapter 18C of the General Laws not later than 18 months after the
2147 development of the online portal established pursuant to section 16P of chapter 6A of the
2148 General Laws.

2149 SECTION 74. Section 16P½ of chapter 6A of the General Laws and section 5D of
2150 chapter 176O of the General Laws shall take effect 1 year after the effective date of this act.

2151 SECTION 75. Subsection (b) of section 16FF chapter 6A of the General Laws shall take
2152 effect on July 16, 2022; provided, however, that the secretary of health and human services may
2153 designate 988 crisis hotline centers before July 16, 2022.

2154 SECTION 76. Section 51¾ of chapter 111 of the General Laws, inserted by section 23,
2155 shall take effect on January 1, 2023; provided, however, the department of public health shall
2156 promulgate regulations to implement said section 51¾ of said chapter 111 not later than October
2157 1, 2022.